

**A Meta-ethnography of Qualitative Accounts of Personal Recovery from Depression  
and, a Qualitative Study Exploring Engagement in the Early Stages of Psychotherapy  
for Depression**

**Natasha E. K. Campbell**

**Submitted for the award of  
Doctor of Clinical Psychology**

**Clinical Psychology Unit**

**University of Sheffield**

**November 2015**



The  
University  
Of  
Sheffield.

Access  
To  
Thesis.

This thesis is protected by the Copyright, Designs and Patents Act 1988. No reproduction is permitted without consent of the author. It is also protected by the Creative Commons Licence allowing Attributions-Non-commercial-No derivatives.

- A bound copy of every thesis which is accepted as worthy for a higher degree, must be deposited in the University of Sheffield Library, where it will be made available for borrowing or consultation in accordance with University Regulations.
- All students registering from 2008-09 onwards are also required to submit an electronic copy of their final, approved thesis. Students who registered prior to 2008-09 may also submit electronically, but this is not required.

Author: NATASHA E.K. CAMPBELL Dept: CLINICAL PSYCHOLOGY UNIT  
Thesis Title: A QUALITATIVE STUDY EXPLORING ENGAGEMENT IN THE INITIAL STAGE OF PSYCHOTHERAPY FOR DEPRESSION Registration No: 144311

**For completion by all students:**

Submit in print form only (for deposit in the University Library):

Submit in print form and also upload to the White Rose eTheses Online server:

In full	<input type="checkbox"/>
Edited eThesis	<input checked="" type="checkbox"/>

Please indicate if there are any embargo restrictions on this thesis. Please note that if no boxes are ticked, you will have consented to your thesis being made available without any restrictions.

Embargo details: (complete only if requesting an embargo to either your print and/or eThesis)

Embargo required?

Length of embargo  
(in years)

Print Thesis	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
eThesis	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

5

**Supervisor:** I, the supervisor, agree to the named thesis being made available under the conditions specified above.

Name: GILLIAN MADDY Dept: Psychology  
Signed: Gillian Maddy Date: 16.10.15

**Student:** I, the author, agree to the named thesis being made available under the conditions specified above.

I give permission to the University of Sheffield to reproduce the print thesis in whole or in part in order to supply single copies for the purpose of research or private study for a non-commercial purpose.

I confirm that this thesis is my own work, and where materials owned by a third party have been used copyright clearance has been obtained. I am aware of the University's *Guidance on the Use of Unfair Means* ([www.sheffield.ac.uk/lets/design/unfair](http://www.sheffield.ac.uk/lets/design/unfair))

I confirm that all copies of the thesis submitted to the University (including electronic copies on CD/DVD) are identical in content.

Name: NATASHA E.K. CAMPBELL Dept: CLINICAL PSYCHOLOGY UNIT  
Signed: Natasha E.K. Campbell Date: 16.10.15

**For completion by students also submitting an electronic thesis (eThesis):**

I, the author, agree that the University of Sheffield's eThesis repository (currently WREO) will make my eThesis available over the internet via an entirely non-exclusive agreement and that, without changing content, WREO may convert my thesis to any medium or format for the purpose of future preservation and accessibility.

I, the author, agree that the metadata relating to the eThesis will normally appear on both the University's eThesis server and the British Library's EThoS service, even if the thesis is subject to an embargo. I agree that a copy of the eThesis may be supplied to the British Library.

I confirm that the upload is identical to the final, examined and awarded version of the thesis as submitted in print to the University for deposit in the Library (unless edited as indicated above).

Name: NATASHA E.K. CAMPBELL Dept: CLINICAL PSYCHOLOGY UNIT  
Signed: Natasha E.K. Campbell Date: 16.10.15

THIS SHEET MUST BE BOUND IN THE FRONT OF THE PRINTED THESIS BEFORE IT IS SUBMITTED

## **Declaration**

This thesis has been submitted for the award of Doctorate in Clinical Psychology at the University of Sheffield. It has not been submitted for any other qualification or to any other academic institution.

### **Structure and Word Count**

Literature review without references	7,882
Research report without references	11,625
References and appendices	7,812
Total word count without references and appendices	19,507
Total word count, including title page for whole thesis, declaration, acknowledgements, word counts page, summary of both parts of thesis, contents, references and appendices	26,988

## **Abstract**

This thesis consists of a literature review and research study. The literature review employed a meta-ethnographic approach to synthesise first person accounts of recovery from depression. Critical appraisal was used to contextualize the rigour of studies. The final synthesis conceptualised recovery as a non-linear process over time, encapsulating periods of relapse and gains over baseline functioning, which could be represented as growth through adversity. A number of interlinked processes worked in concert to support recovery: “recovery toolkit”, “agency”, “being-in-relationships”, “insight”, “stigma”, “resilience” and “hope”. Findings converged with the existing literature on recovery, suggesting that recovery from depression is governed by similar processes to other mental health conditions. The review highlighted the limitations of retrospective accounts and the need for studies which could evaluate the identified gains following recovery on future well-being.

The empirical study used Template Analysis to explore common process of early engagement across two psychotherapies for depression from the clients’ perspective. Sixteen transcripts representing the first two sessions for eight clients receiving either Cognitive Behavioural Therapy or Counselling for Depression were analysed. The analysis found that, in order to engage, clients: (i) must learn about the tasks and principles of therapy; (ii) are active in adapting and managing the relationship with their therapist, and (iii) must be able to flexibly and responsively assert their own agency. The results argue for the active role of the client in managing early engagement. Future research directions and methodological shortcomings are outlined.

## **Acknowledgements**

I would like to thank my research supervisor, Professor Gillian Hardy for her support and wider larger research process. My thanks also to my thesis mentor, Denis Cummin for his balanced and grounded guidance throughout. I would also like to express my gratitude to those close to me who have supported me and kept faith at those moments where I most needed it.

## Table of Contents

Access to Thesis form.....	ii
Declaration.....	iii
Structure and word count.....	iv
Abstract.....	v
Acknowledgements.....	vi

### **Part One: A Meta-ethnography of Qualitative Accounts of Personal Recovery from Depression**

Abstract.....	10
Introduction.....	12
Method.....	15
Results.....	17
Discussion.....	35
Conclusions.....	38
References.....	43

### **Appendices**

Appendix A: Quality assessment by paper .....	53
Appendix B: Quality appraisal checklist .....	56
Appendix C: Summary of themes development.....	58

## **Table of Contents (continued)**

### **Part Two: A Qualitative Study Exploring Engagement in the Early Stages of Psychotherapy for Depression**

Abstract.....	66
Introduction.....	68
Method.....	70
Results.....	75
Discussion.....	97
Conclusion.....	108
References.....	109

#### **Appendices**

Appendix D: Analysis examples.....	117
Appendix E: Ethics approval .....	122
Appendix F: Information and consent forms.....	131



## **Part One: Literature Review**

**A Meta-ethnography of Qualitative Accounts of Personal Recovery from Depression.**

## **Abstract**

**Aim.** To conduct a meta-ethnography of qualitative studies exploring first person accounts of personal recovery from depression in adults.

**Method.** A systematic search of relevant databases was conducted using predefined search terms. Studies meeting the inclusion criteria were selected and evaluated using established quality appraisal criteria. Themes and concepts were extracted and synthesized using a meta-ethnography approach.

**Results.** Seventeen papers representing sixteen studies met the inclusion criteria. The synthesis developed seven linked processes involved in recovery: the “recovery toolkit”, “agency”, “being-in-relationships”, “insight”, “stigma”, “resilience” and “hope” and a final theme describing how recovery was conceptualized.

**Conclusion.** The synthesis developed an understanding of personal recovery as a non-linear process over time which could encapsulate periods of difficulty, and could represent a gain over the pre-depressed self. Recovery is achieved through the combined operation of interdependent processes, in which the importance of enabling relationships, the ability to exercise agency and the development of meaning is highlighted. A limitation of the present review is that it is a synthesis of accounts from participants with differing levels of depression severity and chronicity, level of recovery and exposure to interventions.

### **Practitioner points**

- Clinicians should seek to give a choice in interventions which incorporate individual understanding and preferences.
- Clinicians should be sensitive to and address the operation of internalized stigma which may affect both disclosure of difficulties and accessing help.

- Strengths-based approaches and narrative approaches which may emphasise personal gains may be helpful in promoting a recovery orientation and supporting increased resiliency.
- Clinicians should flexibly adjust interventions according to the individual's preferences and personal understanding of recovery.

## **Introduction**

Depression is one of the most common mental health problems affecting adults and is cited by the World Health Organization (Marcus et al., 2008) as the leading cause of disability with concomitant public health costs (Donohue & Pincus, 2007; Scott & Dickey, 2003). Depression is typically associated with low mood, loss of pleasure and feelings of worthlessness and guilt, which may be accompanied by suicidal ideation and a range of somatic symptoms. Within this constellation of affective, cognitive, behavioural and physical symptoms, individual experiences of depression may differ markedly in their presentation and course (NICE, 2009).

While depression is sometimes experienced as a self-limiting condition (NICE, 2009), re-occurrence is common and depression can develop a chronic, relapsing cycle across the lifetime. Estimates suggest that between 50% and 80% of people will experience a re-occurrence, with further risk of relapse increasing with each new episode (Kessing, Hansen, Andersen, & Angst, 2004). Lifetime prevalence has been conservatively estimated at 20.8% (Kessler et al., 2005).

A range of evidenced based treatments for depression has been developed, including pharmacological and psychological interventions. Psychological therapies recommended by NICE (2009) include cognitive behavioural therapy; interpersonal psychotherapy; problem-solving therapy; counselling; short-term psychodynamic psychotherapy; and couple-focused therapies depending on the presentation and severity.

Talking therapies, either alone or in combination with pharmacological interventions show better efficacy than control conditions (e.g. Barth et al., 2013). However, failure to respond to treatment, premature discontinuation and relapse remain significant problems limiting the efficacy of treatments (Cuijpers et al., 2014; NICE, 2009). A recent meta-analysis of treatments for depression examined long-term follow-up (over

two years) and found that relapse was 53% for psychotherapies and 72% for other treatments (Steinert, Hofmann, Kruse, & Leichsenring, 2014). While heterogeneity of studies, methodological quality, publication bias and other considerations limit the accuracy of specific estimates of response to intervention, relapse and drop-out, the overall patterning in the literature is consistent and supports the need to address how stable recovery can be improved (Cuijpers, et al., 2014; Richards, 2011). Increasing engagement in therapies, reducing dropout and understanding more about “what works for whom” (Norcross & Wampold, 2011) in both the acute phase of treatment and in preventing relapse have been identified as central research needs by NICE (2009).

Improving recovery from depression is further complicated by competing definitions of what is meant by recovery. Outcome measures used by clinical trials and service evaluations typically define recovery by cut-off points on psychometric measures assessing symptom remission and occupational functioning. Amongst others, Barkham et al. (2012) have identified a need to incorporate individual understandings of recovery into outcome measures. The recovery movement has gone some way to defining the meaning of personal recovery (Anthony, 1993). Andresen et al. (2003) provides a succinct definition: “(recovery is) the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination” (p. 588). A recovery orientated approach emphasizes a strengths based approach and living well across a range of personally salient domains which may or may not be accompanied by full symptom remission (Slade, Adam, & O’Hagan, 2012).

Despite the influence of the recovery movement, there has only been one systematic review which has attempted to synthesize the meaning of personal recovery and identify the processes involved. Using a modified narrative synthesis methodology Leamy, Bird, Boutillier, Williams, and Slade (2011) reviewed 97 papers. Recovery processes were

summarized by the acronym “CHIME”: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment.

Leamy et al. (2011) offer a comprehensive and well-researched integration of a diverse body of research, but the review has a number of limitations. Of the 97 papers included, only 37 were qualitative accounts, of which 29 were analyses of interviews or narratives from those recovered or recovering from mental illness. The primacy of direct accounts may therefore have been diluted in the resulting analysis. The majority of articles also focused on severe and enduring mental health problems; only three of the qualitative papers described recovery from depression.

McEvoy, Schauman, Mansell, and Morris (2012) noted that discussion of recovery from depression and other common mental health problems tends to be missing or limited in the more general recovery literature. Previous research reviews of qualitative accounts of depression have tended to examine depression secondary to coping with another primary health or life event such as pregnancy (e.g. Dennis & Chung-Lee, 2006) or chronic disease (DeJean, Giacomini, Vanstone, & Brundisini, 2013). To the present writer’s knowledge, there have been no previous reviews which specifically synthesize the findings from qualitative accounts of recovery from depression. The present literature review aims to fill this gap.

## **Aims**

The present study will:

- i) undertake a systematic review of peer-reviewed studies of personal recovery from depression;
- ii) synthesize the findings using a meta-ethnographic approach to establish how personal recovery from depression is conceptualized and the processes involved;
- iii) identify implications for clinical practice;

- iv) identify areas for further research.

## Method

### Defining the Question

Shaw's (2010) CHIP tool was used to define the parameters of the search question:

Table 1

*CHIP Tool: Parameters of Review Questions*

Components	Description
Context	Depression
How	Qualitative methods
Issue/s	Conceptualization and experience of recovery
Population	Adults

### Inclusion Criteria

- a) Qualitative studies.
- b) Peer reviewed and published in English.
- c) Adult participants.
- d) A Primary focus on depression.
- e) Offer a substantial focus on accounts of personal recovery.

### Exclusion Criteria

- a) Depression secondary to another primary health event e.g. post-partum depression, a physical health condition, another axis one disorder.
- b) Recovery defined only by measures of clinical recovery.
- c) Studies primarily examining response to a formal intervention.
- d) Studies with insufficient exploration of meaning. Kidder and Fine's (1987) criteria was followed to remove studies, which although including non-numerical

data collection techniques, were judged to be insufficiently inductive. Examples might include open ended questionnaires where the responses are analysed to support a hypothesis which is not adapted through the research process or studies where the qualitative element is so small it is lost in the overall positivistic approach of the study.

- e) Studies addressing the experience of depression specific to gerontology, childhood and adolescence.

## Search Methods

Comprehensive searches were carried out between 10 and 19 December 2014 of the following databases: MEDLINE, PsychINFO and Web of Knowledge. Search terms (itemized in Table 2) were developed through consideration of those previously employed within the literature and guidelines for searching for qualitative studies (Britten et al. 2002; Shaw, 2012; Toye et al., 2014).

Table 2

### *Search Terms Employed*

Depression	“depress*” OR “mood disorder*” OR “dysthym*”
AND	
Qualitative methodology	“qualitat*” OR “grounded theor*” OR “phenomenol*” OR “discourse analysis” OR “thematic” OR “ethno*” OR “focus group” OR “hermeneutic*” OR “narrative*” OR “lived experience*” OR “life experience*” OR “theme”
AND	
Recovery	“recover*” OR “living with” OR “cope*” OR “coping” OR “self care” OR “self management”



Google Scholar was used to inspect citations and reference lists of previous reviews and articles meeting the inclusion criteria. Results of the search strategy followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2010).

## **Results**

The search returned 2,278 studies, from which 771 duplicates were removed. The remaining 1,507 articles were screened by title and abstract for relevance, resulting in 75 studies. Of these 60 were excluded for the following reasons: not qualitative accounts, small Q studies, not depression focused or having a co-morbid focus, not sufficiently recovery focused; intervention evaluation; were a secondary comment on primary research, focused exclusively on experience of older adults or adolescents. The references and citations of the final 15 articles were searched and two additional articles found. The results of the search strategy are summarized in the PRISMA diagram in Figure 1.

### **The Synthesis Papers**

Seventeen papers, based on 16 studies, met the inclusion criteria. A summary of the characteristics of each paper is given in Table 3. Severity of depression ranged from mild to severe with recurrent episodes common, including participants with life long presentations. Three studies included bi-polar disorder. Depression status was formally assessed in fourteen of the studies, while participants were described as self-diagnosing in the remainder. Seven studies explicitly described some participants as recovered, or in recovery (two of these studies were drawn from the same sample). The recovery status of the remaining participants was unclear. Of the 393 total participants, 118 were male. Only one of the papers focused exclusively on male-only accounts, while nine were comprised of exclusively female participants. Research was conducted in the USA, India, Sweden,

Australia and the UK. Participant ethnicity was not systematically presented by studies.

The method of data collection was most commonly interviews, either semi-structured ( $n=14$ ) or unstructured ( $n=1$ ), with two studies also employing focus groups. One study asked participants to keep a reflective log. Qualitative methodologies employed by the papers included thematic analysis, grounded theory (or a variant of), phenomenographic analysis, phenomenology, discourse analysis, reflexive methodology, content analysis, and narrative analysis.

### **Quality Assessment**

Total quality appraisal for each paper is given in the final column of Table 3. A detailed breakdown of the quality appraisal by paper is given in Appendix A. The present review applied the generic assessment framework for qualitative research developed by the Critical Appraisal Skills Programme (CASP, 2010). A copy is given in appendix B. Meta-ethnographies do not routinely set a minimum quality threshold for including papers, prioritizing instead conceptual richness and studies which allow data for the synthesis to be extracted (Britten et al., 2002). Quality appraisal was therefore not used to exclude papers, but to provide a ‘quality context’ within which the outcome of the synthesis can be placed. The criteria developed by Dixon-Woods et al. (2005) were used to assign an overall quality rating to each paper of ‘satisfactory’, ‘unable to evaluate’ (due to insufficient information) or “fatally flawed” (methodologically unsound, include but treat with caution). No papers were identified as fatally flawed, but three papers (Chernomas, 1997; Hajela, 2013; Dorwick, Kokanovic, Hegarty, Griffiths, & Gunn, 2008) were reported in insufficient detail to enable an unequivocal rating. Caution must therefore be applied when interpreting the findings of these papers. A second researcher, blind to the first researcher’s ratings, appraised 20% of the papers. Papers were randomly selected. Only 1 CASP criterion for 1 paper was disagreed upon. The disparity was resolved by discussion.

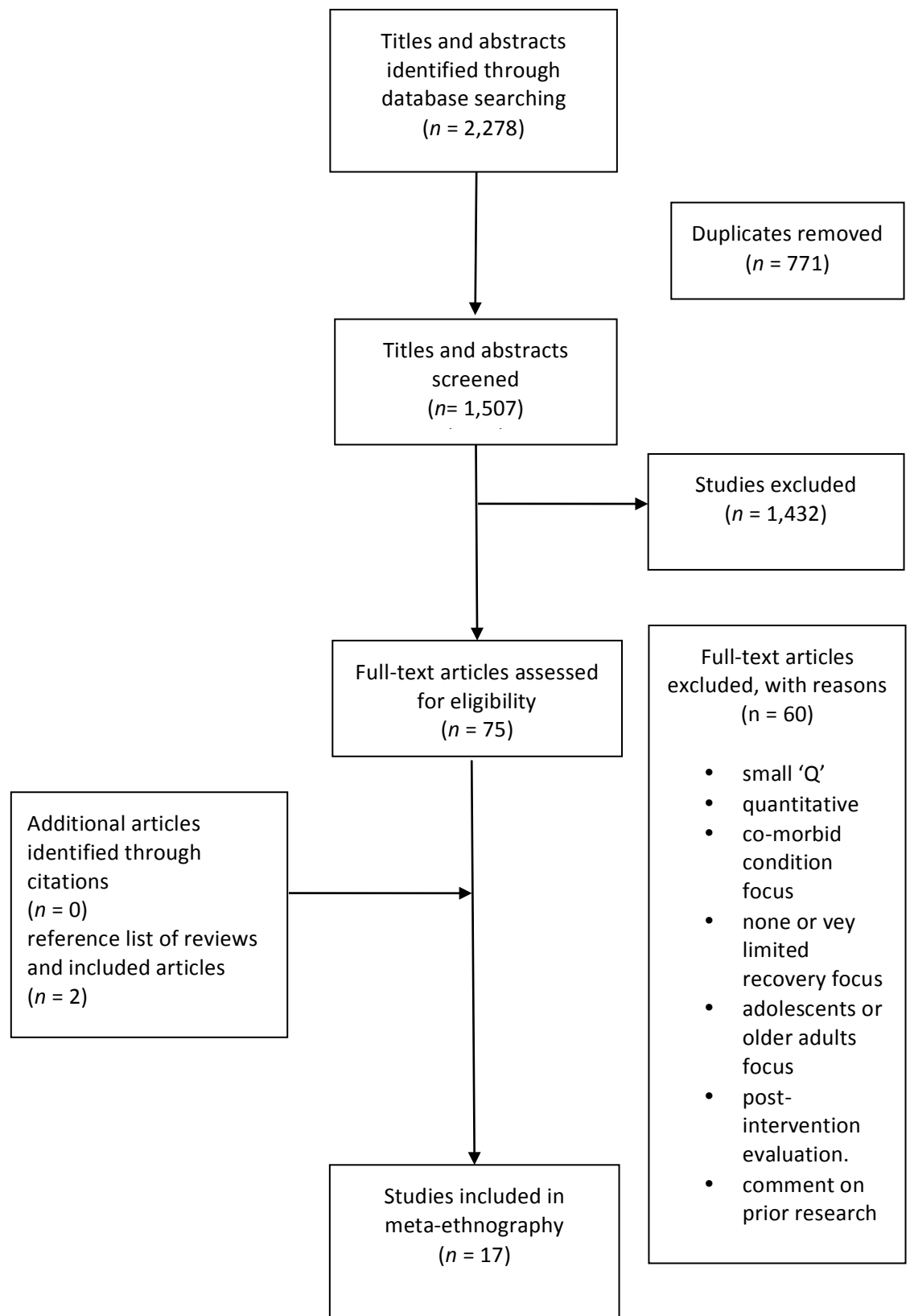


Figure 1 PRISMA flow diagram illustrating search results

Table 3  
*Characteristics and Quality Index Ratings of Studies*

Author(s), year & country	Aim(s)	Participants	Depression & treatment status	Data collection	Analysis method	Quality appraisal*
1. Peden (1993) USA	To describe recovery processes in previously depressed women.	N=7 Female Age=29-53 Ethnicity: n/k	Formal diagnosis of depression, all self-classified as in recovery. All received treatment, type not be established.	Semi-structured interview	Latent content analysis	SAT
2. Peden (1996) USA	To determine recovery status; describe recovery antecedents; and propose interventions.	N=7 Female Age=30-54 Ethnicity: n/k	Formal diagnosis of depression, all self-classified as recovering. All received treatment, type not be established.	Semi-structured interview	Latent content analysis	SAT
3. Schreiber (1996) USA	To examine female descriptions of recovery processes.	N=21 Female Age=32-69 American	Self-report of depression, recovery status n/k. Some received treatment, details could not be established.	Semi-structured interview	Grounded theory	SAT
4. Steen (1996) USA	To explore the meaning of recovery from depression	N=20 Female Age=40-55 Ethnicity: white	Formal diagnosis of depression, all identified as in recovery. All received treatment, details could not be established	Semi-structured interview	Phenomenological	SAT

?

Table 3 (continued)

Author(s), year & country	Aim(s)	Participants	Depression status	Data collection	Analysis method	Quality appraisal*
5. Chernomas (1997) Canada	To examine women's perceptions, experience and recovery from depression.	N=10 Female Age=25-52 years Ethnicity: n/k	Formal diagnosis of depression; all received treatment, details could not be established. Recovery n/k.	Semi-structured interview and journal	Thematic Analysis	
6. Skärsäter, Dencker, Bergbom, Häggström, & Fridlund (2003) Sweden	To describe how women cope with depression using professional and lay support.	N=13 Female Age=18-65 Ethnicity: n/k	Assessed as meeting DSM-IV criteria for major depression. All received treatment, details could not be established. Recovery status n/k.	Semi-structured interview	Phenomenographic analysis	SAT
7. Skarseter, Dencker, Häggström, & Fridlund (2003) Sweden	To describe how men cope with major depression using professional and lay support.	N=12 Male Age=18-65 Ethnicity: n/k	Assessed as meeting DSM-IV criteria for depression. All received treatment, details could not be established. Recovery status n/k.	Semi-structured interview	Phenomenographic analysis	SAT
8. Vidler (2005) Australia	To report women's beliefs on what contributed to depression and recovery.	N=22 (female) Age=22-75 Ethnicity: 9 Australian; remainder undefined	Formal diagnosis of depression; 5 received medication and 13 counselling. 11 no longer meeting a formal clinical cut-off for depression.	Semi-structured interview	Phenomenology	SAT

Table 3 (continued)

Author(s), year & country	Aim(s)	Participants	Depression status	Data collection	Analysis method	Quality appraisal*
9.Lafrance & Stoppard (2006) Canada	To understand women's experience of recovery from depression.	N=15 (female) Age=22-66 Ethnicity: white	Self-identified as previously depressed, now recovered. 13 received medication and/or counselling.	Semi-structured interview	Discourse analysis	
10.Ridge & Ziebland (2006) UK	To understand the meaning of recovery and approaches used.	N=38 (16 male) Age = 18 plus Ethnicity: mixed	Sever depression; diagnostic criteria not given. All received treatment with medication and talking therapies. Recovery status n/k.	Semi-structured interview	Modified grounded theory	SAT
11.Dorwick, Kokanovic, Hegarty, & Griffiths, & Gunn (2008) Australia	What aspects of resilience are important in recovery and how does this compare to professional help.	N=100 (38 male) Age=nk Ethnicity: nk.	All met clinical cut-off for depression using a self-report screening tool. Treatment received n/k. Recovery n/k.	Semi-structured telephone interview	Insufficient description	?
12.Chuick, Grenfeld, Greenberg, Shepard, Cochran, & Haley (2009) USA	To explore men's experience of depression.	N=15 (male) Age=24-75 Ethnicity: 14 American, 1 native American	All had previous diagnosis of depression. All received some form of treatment. Recovery status n/k.	Semi-structured interview	Grounded theory	SAT
13.Michalak, Livingston, & Hole (2011) Canada	To understand the experience of stigma in the context of self-management strategies.	N= 32 (male:12) Age=28-54 Ethnicity: mixed	Bipolar- type 1 and 2. Treatment received n/k. Recovery status n/k.	Focus groups or semi-structured interview	Thematic analysis	SAT

Table 3 (continued)

Author(s), year & country	Aim(s)	Participants	Depression status	Data collection	Analysis method	Quality appraisal*
14. Murray, Suto, Hole, Hale, Amari, & Michalak (2011) Canada	To provide a description of effective self-management strategies.	N=33 (male 12) Age=28–54 Ethnicity: n/k	Bipolar- type 1 and 2 Treatment received not could be established. Recovery status n/k.	Focus group or semi-structured interview	Thematic analysis	SAT
15. Nunstedt, Nilsson, Skarsater, & Kylen (2012) Sweden	To describe how individuals understand depression and how this informs recovery.	N=20 (6 male) Age=23–68 Ethnicity: Swedish 13; non-Swedish 7	All met DSM-IV criteria for major depression. All received treatment, type not described. Recovery status n/k.	Semi-structure interview	Content analysis	SAT
16. Hajela (2013) India	To examine how people understand and recover from depression.	N=25 (7 male) Age=24–35 Ethnicity: n/k.	Diagnosis of first episode depression. All had been offered medication, but declined. No other treatments described. All self-identified as recovered.	Unstructured narrative interview	Narrative analysis	SAT
17. Fernandez, Breen & Simpson (2014) Australia	To explore the experiences of loss, coping, and recovery in women living with bi-polar disorder	N=10 female Age=29–68 Ethnicity n/k	Formal diagnosis, all receiving out-patient treatment. Treatment not described. Recovery status n/k.	Semi-structured Interview	Grounded theory	SAT

\* SAT = satisfactory; ? = could not rate quality, include but treat with caution

## **The Synthesis Process**

The present review used the meta-ethnography approach (Noblit & Hare, 1988) to synthesize the findings from the qualitative papers. Meta-ethnographies have shown increasing value in health related research including the synthesis of methodologically heterogeneous studies (Campbell et al., 2011; Dixon-Woods et al., 2007). The interpretative nature of the approach goes beyond a merely aggregative technique and may support the development of new conceptual insights and theory (Britten et al., 2002; Campbell et al., 2011; France et al., 2014).

Meta-ethnography involves identifying the original themes or key concepts developed in the original studies, sometimes referred to as second order constructs and comparing these within and between studies through a process of reciprocal translation (Campbell et al., 2011; France et al., 2014). The process may be likened, as France et al., (2014) note, to the constant comparative method. Noblit and Hare (1988) identified three types of synthesis: “reciprocal”, where the findings of studies are broadly similar; “refutational”, where the findings of studies appear to conflict with each other, and a “line-of-argument” approach, which involves translating one study into another in order to develop a new framework. Meta-ethnographies may contain more than one type of synthesis depending on the relationship between studies. The method described follows the stages of meta-ethnography proposed by Noblit and Hare (1988) and developed by previous meta-ethnographies (Britten et al., 2002; France, et al., 2014; Malpass et al., 2009).

## **Reading the studies**

Articles were read and re-read in date order, beginning with the earliest paper. A table was created in Excel and this was used to record examples of participant quotes and second order constructs developed by the authors. Thoughts about each second order construct were noted and aided the development of key concepts.



**Determining how the studies were related.** The key concepts were then systematically compared and searched for across all papers, identifying recurring ideas. A word or phrase was then developed which best represented these groupings of key concepts between papers.

**Translating one study into another.** In order to translate one study into another, a grid was completed by entering each paper into a column, and concepts across the rows. The second order constructs from each paper were then added. Completing the table ensured that each construct in the source paper was encompassed in an over-arching concept. A summary of each group of second order constructs defined by an over-arching concept was written. Appendix C provides the summary table of the second order constructs and their over-arching category and the studies to which they belong.

**Synthesizing translations.** The process of creating the table demonstrated that there were a large number of reciprocal relationships between the ideas found in the 16 studies. Not all themes were fully articulated in each paper, nor were all ideas apparent across all studies; however, these differences did not function as refutations, but developed into a line of argument. Appendix C illustrates the new interpretations and their relationship to the over-arching category and original second order constructs. A number of these interpretations were close to the original second order constructs, while others arose from further interpretation of overall processes linking the papers. The themes addressed processes of recovery from depression and how recovery was conceptualized.

## **Findings**

The eight themes developed through the process of reciprocal translation are described below. Each theme operated in a complex relationship with others to describe processes involved in recovery and how personal recovery is conceptualized; for example, utilizing external support was facilitated by good relationships with providers. Examples of

papers are incorporating the themes are cited. The eight overarching themes are given in bold, and sub themes are italicized.

### **Developing a Recovery ‘Tool Kit’**

The process of recovery involved combining personal resources with support from external sources to develop a personal ‘toolkit’ of selected strategies that facilitated recovery (Peden, 1993, 1996; Ridge & Ziebland, 2006; Skärsäter, Dencker, Bergbom, Häggström, & Fridlund, 2003; Skärsäter Dencker, Häggström, & Fridlund, 2003). This included utilizing a range of external, professional, and personal resources and the exercise of choice in what to apply when. Developing personal resources built on existing strengths as well as acquiring new skills

***Choosing*** involved the active participation in choices over treatment options and tailoring those choices to meet personal needs (Peden, 1993, 1996; Ridge & Ziebland, 2006; Skarseter, Dencker, Bergbom et al. 2003; Skarseter, Dencker et al., 2003; Vidler, 2005).

***Utilizing external resources.*** At its most basic level, information was sought about depression, which in turn legitimated personal suffering as something which was not reducible to personal failure (Skärsäter, Dencker et al., 2003). For some, ‘naming’ depression provided a vocabulary to frame their experience and make it comprehensible (Hajela, 2013; Nunstedt, Skärsäter, & Kylén 2012; Skärsäter, Dencker et al., 2003). Information about depression helped reduce a sense of personal failure and increased feelings of control (Chuick et al., 2009; Skärsäter, Dencker, Bergbom et al., 2003; Steen, 1996), while also practically signposting individuals towards ways of combatting depression (Chuick et al., 2009; Murray et al., 2011).

Tailored support from professionals enabled individuals to develop skills to support recovery (Murray et al., 2011; Peden, 1993, 1996; Ridge & Ziebland, 2006). In the early

stages of recovery, utilizing professional help gave some a sense of “safety”, a feeling of becoming “unburdened” (Skärsäter, Dencker, Bergbom et al., 2003) and was integral to the awakening of hope (Chuick et al., 2009). Encounters with professionals were most helpful where the relationship held the quality of ‘concordance’ (Skärsäter, Dencker, Bergbom et al., 2003) or ‘fit’ (Peden, 1993) and helped individuals trust the advice of others (Murray et al., 2011).

***Personal strategies.*** In addition to external sources of help, accounts emphasized developing a personal set of responses to overcome depression. These were often arrived at through a process of trial and error (Chuick et al., 2009) but also included identifying and extending personal strengths (Dowrick, Kokanovic, Hegarty, Griffiths, & Gunn, 2008; Steen, 1996), as well as learning new skills (Peden, 1993, 1996; Ridge & Ziebland, 2006). Examples included addressing cognitions and attitudes to change; learning to meditate; taking care of the self through diet, exercise and sleep; learning to say ‘no’, and making changes to the structures of everyday life which were unhelpful (Dowrick et al., 2008; Fernandez et al., 2014; Hajela, 2013; Lafrance & Stoppard, 2006; Murray et al., 2011). Individuals learned to monitor for signs of relapse, while developing long term plans to maintain wellbeing (Murray et al., 2011). Chernomas (1997) referred to the process as developing the ‘self as healer’ while Dowrick et al. (2008) coined the phrase ‘personal medicine’ to convey the centrality of these activities in recovery.

The choice of how to balance personal and professional support differed across accounts but was characteristically an active process (e.g. Skärsäter, Dencker, Bergbom et al., 2003; Skärsäter, Dencker et al., 2003; Steen, 1996), preceded by a decision to engage in recovery (Peden, 1993) and required the ability to trust one’s own understanding (Murray et al., 2011). Accounts emphasized the exercise of choice and autonomy; however, this was achieved in and through relationships, both professional and personal.

## **Turning-to-Relationship**

Re-connecting with others was inherent in the recovery process across all the papers, though not always developed as a theme, and functioned as a counter-point to the isolating effect of depression (Skärsäter, Dencker et al., 2003). Accounts emphasized that re-connecting did not signify a passive dependency on others, but an active-being-in-relationship. For many turning to relationships also involved problem solving relational difficulties which may have contributed to becoming depressed (Lafrance & Stoppard, 2006).

***Talking about depression.*** Talking to others included professionals, friends and family. An initial opening up to others about the experience of depression frequently represented a “turning point” (Peden, 1993) in recovery, allowing individuals to receive validation of their experience as well as social support and the opportunity to develop more authentic relationships (Murray et al., 2011; Skärsäter, Dencker, Bergbom et al., 2003; Skärsäter, Dencker et al., 2003).

***Selective disclosure.*** Accounts emphasized that the choice to disclose the experience of depression was in the face of fears of rejection and perceived stigma (e.g. Fernandez Breen, & Simpson, 2014; Hajela, 2013). For some, a concrete experience of previous stigmatization increased their wariness to share and led to care in what to disclose to whom (e.g. Chernomas, 1997).

***Being-in-relationship.*** Turning to relationships was not about passive help seeking, but the desire to cultivate authentic and reciprocal relationships, which placed the individual in a social network (Skärsäter, Dencker, Bergbom et al., 2003; Skärsäter, Dencker et al., 2003). Within these supportive and safe, but emancipating relationships, accepting and belonging led to a sense of personal validation as individuals increased their social networks (Chernomas, 1997; Dorwick et al., 2008). Being-in-relationship enabled a

sharing of experience and connection with others (Murray et al., 2011). The harnessing and extending of “personal and affectional bonds” identified by (Dowrick et al., 2008) distinguished a recovery-enhancing self-reliance from the ‘going it alone’ mindset which led to isolating and concealing the self from others, which was implicated in the maintenance of depression (Murray et al., 2011; Ridge & Ziebland, 2006).

***Re-negotiating relationships.*** The quality of helpful relationships was in contrast to problematic relationship roles which may have contributed to becoming depressed. Within accounts of women’s recovery (e.g. Peden, 1996; Schreiber, 1996), the importance of increased assertiveness and the development of healthy boundaries to combat a passive ‘pleasing’ was emphasized (Lafrance & Stoppard, 2006; Skärsäter, Dencker et al., 2003). However, while the particular relational dilemmas held a gendered quality, the need to address the quality of relationships to enable a more authentic self in-relationship was present in accounts from both men and women (Ridge & Ziebland, 2006; Vidler, 2005).

### **Increasing Insight**

Insight into the factors which contributed to the development and maintenance of depression was a characteristic part of recovery and was woven into a search for meaning and developing a “narrative of recovery” (Dowrick et al., 2008; Ridge & Ziebland, 2006). The development of personal insight represented a gain over the pre-depressed self in many papers. Insight could develop through personal reflection, formal interventions and relationships.

***Insight into the onset and maintenance depression.*** Depression often crept up on individuals and was characterized as ‘experiencing but not understanding’ by Nunstedt, et al. (2012). ‘Awakening’ (Nunstedt, et al., 2012) to the presence of depression was an important part of recovery. For some, insight came through the intercession of others who named the depressed experience (Hajela, 2013), while for others a change of perspective

came as a result of ‘hitting rock bottom’ (Peden, 1993). Insight included awareness of destructive thought patterns and behaviours; and letting go of distorted messages from earlier developmental stages (Ridge & Ziebland, 2006; Steen, 1996).

***Meaning making and self-understanding.*** Some papers found that limited insight appeared to parallel limited recovery (Peden, 1993). Nunstedt et al. (2012) made the distinction that mere ‘knowledge’ about or memory of depression was of limited value, and individuals were required to develop an ‘individually constructed’ understanding of their own depression to benefit self-management or recovery. This aspect of meaning making was integral to recovery for many (Chernomas, 1997; Hajela, 2013; Peden, 1993, 1996) and was facilitated by the growth of “reflexive awareness” identified by Ridge and Ziebland (2006).

A number of accounts described how increased self-understanding led to a new relationship with the self (Skärsäter, Dencker et al., 2003). This was variously referred to as ‘seeing with clarity’ (Schreiber, 1996), ‘a journey of self-discovery’ (Hajela, 2013) and ‘clueing-in’ (Schreiber, 1996). These metaphors described a level of personal insight which was emotionally and cognitively congruent and which were a precursor to change at the level of identity. As Ridge and Ziebland (2006) noted, the opportunity for a new understanding of the self appeared to arise out of the “loss of self” experienced by so many in depression (Ridge & Ziebland, 2006).

***Re-organisation of the self.*** The “creation of a more useful story about the self” (Ridge & Ziebland, 2006, p. 1044) led to a degree of change that equated to a transformation at the level of identity across many studies. The first step in this process was how individuals negotiated a diagnosis of depression. Some accounts, particularly (Lafrance & Stoppard, 2006; Michalak et al., 201; Murray et al., 2011) discussed how an illness identity could be stigmatising and disempowering where it held a totalizing effect on

the person's experience of self, rather than distinguishing between depression as one aspect of experience (Ridge & Ziebland, 2006). Fernandez et al.'s, (2014) participants talked about, having a 'well' and a 'sick' identity, and the need to develop an integrated understanding of the self through nourishing the positive aspects of self-compassion, tolerance, empathy, creativity, and strength.

Ridge and Ziebland (2006) described this as 're-writing' the experience of depression into the self and identified how participants moved from seeing depression as a 'enemy' of the self, to an experience which brought a valued increase in self-understanding and an alternative way of living (Ridge & Ziebland, 2006). Some accounts suggested that changes at the level of self involved addressing gendered roles, for example self-sacrifice (Lafrance & Stoppard, 2006), while Schreiber's (1996) participant talked about 'discarding the not me' in order to feel more whole and complete. This renegotiated identity allowed for a more authentic living in the world and was linked to enhanced acceptance of self and others (Fernandez et al., 2014; Schreiber, 1996; Skärsäter, Dencker, Bergbom et al., 2003).

### **Agency**

An increase in personal agency informed the other process of recovery.

***Determination.*** Early in the recovery process, a sense of agency began to form through the 'determination' (Peden, 1993); and was subsequently fostered by feeling empowered to take personal responsibility for recovery (Ridge & Ziebland, 2006; Steen, 1996).

***Aloneness – togetherness.*** A number of papers struggled with an apparent contradiction between a form of self-reliance, which had isolated individuals and prevented help seeking, with the role of increased autonomy in recovery. The distinction lay in how individuals related to others. In relation to treatment providers, this was expressed through developing a sense of collaboration (Murray et al., 2011), concordance (Skärsäter et al.,

2003), choice and autonomy in decision-making (Murray et al., 2011). Fernandez et al. (2014) described the role of the ‘independent patient’ as a way of navigating the apparent paradox of needing help while remaining autonomous. Within personal relationships, agency developed through re-negotiating and setting functional interpersonal boundaries (Lafrance & Stoppard, 2006); a process Vidler (2005) characterized as self-agency in contrast to other-agency.

***The empowered self.*** Developing a sense of agency was supported by cognitive understandings of depression, but this also needed to be grounded in the individual’s emotional experience: Schreiber (1996) described this as “clueing in”. Agency also functioned at the level of identity to develop a new active and empowered self (Michalak et al., 2011) which contrasted with the ‘disempowering’ effect of depression (Skärsäter, Dencker, Bergbom et al., 2003; Steen, 1996).

## **Stigma**

Stigma was explicitly developed in only a minority of studies (Michalak et al., 2011), however, fear of negative evaluations by others and an internalized shame for being depressed was suggested across many accounts and needed to be negotiated as part of recovery (Chuick et al., 2009; Schreiber, 1996; Vidler, 2005). Stigma was experienced as a negative evaluation experienced by both genders in terms of a failure to fulfil idealized gender roles. For example, Skärsäter, Dencker, Bergbom et al. (2003) found that female participants talked about a fear that they might be perceived as not fulfilling a caring role adequately, while men talked about the limiting relationship between traditional masculinity and the ability to openly express feeling (Skärsäter, Dencker, Bergbom et al., 2003). Dowrick et al. (2008) and Chuick et al. (2009) observed that the favouring of self-help over sourcing professional help was influenced by perceptions of stigma.



*Overcoming stigma* involved addressing both external and internalized experiences and recognising that depression is part of, but not the whole of the self (Chernomas, 1996; Fernandez et al., 2014; Michalak, et al., 2011; Nunstedt et al., 2012), as well as educating others (Murray et al., 2011).

### **Personal Resilience**

The recovery processes named above coalesced around a further theme best captured as an increase in personal resiliency. Resilience, the ability to cope with adversity, is commonly conceptualized as a protective factor against depression, but resilience can also develop out of ‘turning point’ experiences in adulthood (Rutter, 2006). Within the accounts of recovery in the present papers, resilience developed as a response to the adversity of depression through recognizing and increasing personal resources. The ability to build relationships, an increase in agency and an increase in reflective capacity are consistent with Hauser’s definition of resilience as a response to mental illness (Hauser, 2007). The growth of resilience as an outcome was explicitly developed by Dorwick et al. (2008). Dorwick et al., (2008) coined the phrase ‘ordinary magic’ to the buffering effect of relationships against difficulties; and ‘personal medicine’ as the active development of personal resources. Resilience increased the individual’s capacity to bear with the pain of depression in the knowledge that depression was resolvable and was intimately linked to the development of hope (e.g. Murray et al., 2011).

### **Hope**

The installation of hope, however small, was a necessary precursor to engagement in recovery. In the early stages, ‘hope’ sometimes came through the intercession of others (Peden, 1993,1996; Hajela, 2013; Skärsäter, Dencker, Bergbom et al., 2003; Skärsäter, Dencker et al., 2003), but for recovery to progress, hope flourished alongside a belief in one’s ability to cope and the development of personal agency (Chuick et al., 2009;

Skärsäter, Dencker et al., 2003; Fernandez et al., 2014). Ridge and Ziebland (2006) linked the development of hope to the growth of a more authentic life anchored in social relationships with others.

### **Conceptualizations of Recovery**

***A dynamic process.*** Across the studies, recovery was conceptualized as a dynamic process, taking place over time, but seldom linear. Each of the themes described above represented processes which worked in concert to enable recovery. While some papers attempted to map specific process to discrete stages of recovery (Peden, 1993, 1996; Schreiber, 1996; Steen, 1996) the overall picture suggested a more blended and fluid process, which, while suggestive of recovery stages, did not clearly delineate processes to be exclusive property of a discrete stage. Recovery was often long (e.g. Ridge & Ziebland, 2006) and experienced as a personal struggle, with some accounts employing graphic metaphors to emphasise the difficulties that needed to be addressed (Hajela, 2013). Recovery was understood as property of the self, but a self-in-relationship with a community of others who offered appropriately tailored help. Accounts of those experiencing chronic depression conveyed a tacit acceptance that depression may re-occur but some degree of confidence that this suffering could be borne with and managed.

***A gain over the pre-depressed self.*** Recovery was understood by some as a restoration of pre-morbid functioning, however, many accounts described gains following the experience of depression (e.g. Peden, 1996). The recognition of ‘gains’ was implicit in many of the other themes of insight, identity and agency. Some accounts developed this further and described a profound transformation in which a new self had arisen from the loss of self connected to the depressed experience (Ridge & Ziebland, 2006).

***Naming recovery.*** Some accounts highlighted the need to consciously develop a ‘language of recovery’. Participants in Ridge and Ziebland’s (2006) study identified this

was missing from their experience of health care and consequently, it had taken many years to identify that they were ‘in recovery’.

### **Discussion**

This meta-ethnography used a line of argument approach to synthesise qualitative accounts of personal recovery from depression from 17 papers representing 16 studies. The analysis developed eight themes, of which seven describe the processes involved in recovery: the ‘recovery toolkit’, ‘agency’, ‘turning-to-relationships’, ‘insight’, ‘stigma’, ‘resilience’ and ‘hope’. The final theme described how personal recovery was conceptualized.

The themes developed offer broad conceptual overlap with Leamy et al.’s (2011) five processes of: ‘connectedness’, ‘hope’, ‘identity’ (including overcoming stigma), ‘meaning in life’, and ‘empowerment’. The similarity of the processes to those in the present meta-ethnography suggests that recovery from depression shares common processes with other mental health conditions, however, there were some notable differences in how themes were defined and ‘resiliency’ was absent from Leamy et al.’s (2011) study. Key differences are now discussed, beginning with the role of relationships in recovery. Leamy et al. (2011) identify the importance of supportive relationships in recovery; however, the present review develops this further and highlights the complexity involved in re-negotiating relationships which may have contributed to depression and the need to establish relationships which enable support and mutuality while respecting autonomy. Hobson’s (1985) concept of ‘aloneness-togetherness’ was used to capture this quality and was placed within the overall theme of agency to indicate the relational quality inherent in developing the argentic self. The relational dimension of agency is missing from Leamy et al.’s (2011) review which instead identifies the need for ‘empowerment’, which is defined as identifying personal strengths. Leamy et al.’s (2011) third category,

‘identity’, was captured in the present study under a process of ‘increased insight’ and ‘re-organisation of the self’. Similar to Leamy et al. (2011), this category held the quality of personal change, however, within the present review, it was intimately connected to narrative processes of meaning making. While Leamy et al.’s (2011) review acknowledges the importance of finding ‘meaning in life’, meaning making as an active, reflexive, narrative process which contributed to a ‘reorganisation of the self’ was absent. Missing from Leamy et al.’s (2011) themes is the concept of ‘resiliency’ developing through overcoming depression. In developing resilience as a theme, the present review emphasis is that recovery from depression can be understood as an experience of growth through adversity.

In discussing their overall conceptualisation of recovery, Leamy et al. (2011) argue for a stage model understanding of recovery and map their themes onto Prochaska and DiClemente’s (1982) transtheoretical model of change (TMC). The findings of studies in the present review did not offer enough evidence to either support or refute this model, however, the fluidity of the process described suggest that care needed to be taken in making a categorical assignment of different processes to discrete stages of recovery in depression. Leamy et al. (2011) do not report their themes in sufficient detail to enable further comparison with the present study. It is consequently unclear whether the differences identified result from alternative methodologies and inclusion criteria, or represent depression specific aspects of recovery.

The themes within the present study support the need to develop a narrative of recovery as a counterpoint to the decline narratives identified by Ridgeway (2001) as common within mental health. Within the present review, the features of a recovery narrative include both making sense of the depressed experience and identifying gains across a range of personally salient domains, including self-understanding, recovery skills,

reflexivity, and relationships, which contributed to increased resilience. Bruner (1991) argues the position that narratives are not just the expression of inner states, but are determining of subsequent experience and identity formation.

The recent growth in literature on post-traumatic growth has begun to research more fully how adverse experiences may be a means of personal transformation (Barratt, 2014) and foster the development of increased resiliency as highlighted in the present review. The literature largely focuses on physical illness, but emerging models have begun to be applied to recovery from mental health problems. Dunkley and Bates (2014) applied Tedeschi and Calhoun's (2004) model of post-traumatic growth (PTG) to recovery from first-episode psychosis to demonstrate a gain over pre-morbid functioning. Tedeschi and Calhoun, (2004) propose that change may arise when something is so threatening it undermines existing schemas and in doing so, creates the conditions for cognitive rebuilding and opportunities for growth. As a consequence, resiliency increases as a new experience of successfully negotiating adversity is built into the understanding of the self (Seery, Holman, & Silver, 2010). A number of studies support the view that resilience may develop from successfully overcoming adversity (e.g. Aldwin, Sutton, & Lachman, 1996), leading to an understanding of resiliency as a set of dynamic processes which may develop over time (Fletcher & Sarkar, 2015; Rutter, 2006) and which may include periods of pathology and psychological illness (van Vliet, 2008). This literature has similarities to the findings of the present review whereby depression may function as an experience which is a fundamental threat to self – thus, the point of experience named in a number of studies which necessitates the reappraisal and development of the self. While this re-structuring does not prevent further episodes, it can lead to an increased sense of being able to better manage these from which hope which mitigates the despair of depression is maintained.

Within the present review, the quality of the relational environment was

instrumental in enabling and supporting other recovery processes. The importance of the individual's relational environment is replicated across the literature on recovery from adversity (Spaniol, Bellingham, & Cohen, 2003). However, relational dynamics held two areas of complexity: the apparent paradox of needing support while also striving to attain greater self agency as well as the need to renegotiate the unhelpful relationship patterns that may have contributed to an individual's depression.

Feeney and Collins (2015a, 2015b) draw on the principles of attachment theory to propose a model of how helping relationships may have both a protective and enabling function. Such relationships provide support while respecting personal autonomy, and are neither controlling, over-involved, neglectful or dismissive. Feeney and Collins (2015a) described this as "dependence in response to genuine need", "optimal independence" (a healthy degree of autonomy), and "optimal interdependence" (relationships characterized by mutual dependence).

Aldwin et al. (1996) suggest that accessing the support of others in times of distress, while challenging, if achieved, may facilitate a corrective experience which may help to positively shift internal representations of self and others. The changes described in a number of studies within this review suggest that patterns of relating changed for many; however, it is not clear whether this represented shifts in attachment style or enduring changes in interpersonal functioning.

## **Conclusion**

This meta-ethnography synthesized the findings of 17 qualitative papers representing 16 studies, which examined experiences of recovering from depression. The themes were identified: the "recovery toolkit", "agency", "being-in-relationship", "insight", "stigma", "resilience" and "hope". The final theme described how personal recovery was conceptualized. The themes were broadly consistent with those in the wider recovery

literature, however, the present review highlighted the need to identify areas of complexity in how themes contribute to recovery. The themes functioned in concert and highlighted the importance of relationship, personal choice and the exercise of autonomy. Accounts emphasized that recovery was not just a return to pre-morbid functioning, but represented personal growth and the development of skills to enhance resiliency.

### **Limitations**

An inherent bias is that the review was reliant on the selection techniques of individual studies. The studies combined accounts from participants whose experience of depression differed widely in terms of severity and chronicity, stage of recovery and exposure to interventions. Each of these factors may have a bearing on the process identified. Also of particular note was the small number of studies examining male only experiences and those representing ethnic diversity which prevented a meaningful analysis of how these dimensions may affect recovery.

Studies varied in their methodological rigour. Limited reporting of methodology was particularly apparent in some studies and three studies could not be classified as satisfactory due to the absence of key information. The results of these studies were included due to their conceptual value, however, there is the need for increased transparency in the reporting of qualitative studies in order to support more robust and reliable synthesis.

The final synthesis produced results which have broad overlap with existing understandings of recovery process. This meant the original aim which informed the adoption of a meta-ethnographic approach to support the development of new insights and theory building was not achieved, but this was not predictable at the start of the review process and the importance of a synthesis method open to new interpretations was justified.

Finally, inherent in the nature of meta-ethnographies, lies a process of

interpretation. As Malpass et al. (2009) note, the interpretative nature of synthesis means that other ways of understanding and developing themes could have been arrived at by an alternative researcher. Only published peer-reviewed papers were included in this analysis, therefore material from the ‘grey’ literature was omitted. Consequently, certain accounts of recovery from depression may have been lost.

### **Research implications**

Understanding how individuals apply previous recovery experiences to further episodes of depression requires further analysis. This may apply to both resources individuals develop within themselves and also the extent to which the individual can build up relational ‘capital’ to increase their future resilience. Criticism of the adversarial growth literature argued that research based on retrospective self reports are open to the question of whether growth has objectively taken place (Bonanno, 2005). Studies utilizing measures such as baseline functioning and providing objective measures of increased functioning are needed. Further understanding is also needed to identify whether benefiting from appropriate help may result in changes at the level of interpersonal functioning and attachment status and how this may be linked to recovery. Such research could also be supported by developing outcome measures to address perceptions of growth and meaning making processes developed through adversity.

More detailed understanding of how individuals achieve the processes described by the themes is also required, for example, how individuals turn from isolating the self to accepting relational support in depression, or how the development of a recovery positive story is developed and is maintained through subsequent episodes of depression which are typically associated with negative cognitive biases (Gotlib & Joorman, 2010).

The studies had a number of weaknesses which could be addressed by future research. Firstly, additional commentary would be valuable on the authors’ reflexive



processes and how these may have influenced factors such the structuring of interview questions, as well as data analysis. Secondly, greater levels of methodological detail are needed in order to aid assessment of study quality. Thirdly, consideration of participant experience and background in terms of access to treatment, as well as severity and chronicity of depression would be particularly valuable. Research could profitably examine how each of these dimensions influences accounts of recovery processes.

The relationship between gender and recovery from depression needs to be examined further, particularly regarding the limited number of studies examining male experiences of recovery. Future research needs to be open to both commonalities and differences of experiences between men and women. Finally, it should be noted that all narratives, including recovery from depression, are culturally grounded. Future research needs to address the experience from alternative cultural experiences.

### **Clinical Implications**

Clinicians working with depressed individuals should seek to incorporate individual preferences in interventions to support recovery. Clinicians may also be mindful of the subtle operation of internalized stigma and how this may be combatted. Strengths-based approaches (e.g. Padesky & Mooney, 2012; Seligman & Csikszentmihalyi, 2000) may also usefully form an adjunctive component in existing evidenced based treatments for depression such as cognitive behavioural therapy, interpersonal therapy, and antidepressant medication (Seligman, Rashid, & Parks, 2006). Lewis (2006) has demonstrated how positive psychology tools may be integrated with existing treatments for severe depression linked to trauma and attachment relationships. The centrality of meaning suggests that taking a narrative focus which helps individuals frame aversive experiences in terms of meaning, purpose, and gains may help individuals develop a personal narrative of recovery.

Finally, clinicians need to be supportive of fostering personal agency within a

supportive and secure relationship. Sensitivity is needed in assessing the quality of attachment and interpersonal process in their relationship relative to the individuals' needs, and the ability to flexibly adjust to the individuals changing needs relative to the non-linear quality of the recovery journey.

## References

- Aldwin, C. M., Sutton, K. J., & Lachman, M. (1996). The development of coping resources in adulthood. *Journal of Personality*, 64, 837-871. doi:10.1111/j.1467-6494.1996.tb00946.x
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed). Washington, DC: American Psychiatric Association
- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*, 37, 586-594. doi:10.1046/j.1440-1614.2003.01234.x
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16, 11-23. doi:10.1037/h0095655
- Barkham, M., Stiles, W.B., Connell, J., Mellor-Clark, J. (2012) Psychological treatment outcomes in routine NHS services: what do we mean by treatment effectiveness? *Psychology and Psychotherapy: Theory, Research and Practice*, 85, 1–16. doi:10.1111/j.2044-8341.2011.02019.x
- Barratt, T. M. (2014). *Perceptions of growth in depression: An interpretative phenomenological analysis*. Retrieved from <http://repository.asu.edu/items/21040>.
- Barth, J., Munder, T., Gerger, H., Nüesch, E., Trelle, S., Znoj, H., Juni, P. & Cuijpers, P. (2013). Comparative efficacy of seven psychotherapeutic interventions for patients with depression: a network meta-analysis. *PLOS Medicine*, 10, 1-17. doi:10.1371/journal.pmed.1001454
- Bonanno, G. A. (2005). Clarifying and extending the construct of adult resilience. *American Psychologist*, 60, 265-267. doi:10.1037/0003-066X.60.3.265b

- Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta-ethnography to synthesise qualitative research: a worked example. *Journal of Health Services Research & Policy*, 7, 209-215. doi: 10.3310/hta15430
- Bruner, J. (1991). The narrative construction of reality. *Critical Inquiry*, 18, 1-21. Retrieved from: <http://www.jstor.org/stable/1343711>
- Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., & Donovan, J. (2011). Evaluating meta-ethnography: systematic analysis and synthesis of qualitative research. *Health Technology Assessment*, 15. doi:10.3310/hta15430
- Critical Appraisal Skills Programme (2010). Making sense of evidence about clinical effectiveness: 10 questions to help you make sense of qualitative research. Retrieved from <http://www.casp-uk.net/>
- Chernomas, W. M. (1997). Experiencing depression: women's perspectives in recovery. *Journal of Psychiatric and Mental Health Nursing*, 4, 393-400. Retrieved from: <http://europepmc.org/abstract/med/9505633>
- Chuick, C. D., Greenfeld, J. M., Greenberg, S. T., Shepard, S. J., Cochran, S. V., & Haley, J. T. (2009). A qualitative investigation of depression in men. *Psychology of Men & Masculinity*, 10, 302-3012. doi:10.1037/a0016672
- Cuijpers, P., Karyotaki, E., Weitz, E., Andersson, G., Hollon, S. D., & van Straten, A. (2014). The effects of psychotherapies for major depression in adults on remission, recovery and improvement: a meta-analysis. *Journal of Affective Disorders*, 159, 118-126. doi:10.1016/j.jad.2014.02.026
- DeJean, D., Giacomini, M., Vanstone, M., & Brundisini, F. (2013). Patient experiences of depression and anxiety with chronic disease: a systematic review and qualitative meta-synthesis. *Ontario Health Technology Assessment Series*, 13. Retrieved from:

<http://www.hqontario.ca/en/documents/eds/2013/full-report-OCDM-depression-and-anxiety.pdf>.

- Dennis, C. L., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: a qualitative systematic review. *Birth*, 33, 323-331. doi:10.1111/j.1523-536X.2006.00130.x
- Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young, B., Jones, D. (2007). Appraising qualitative research for inclusion in systematic reviews: A quantitative and qualitative comparison of three methods. *Journal of Health Service Research Policy*, 12, 42-47. doi:10.1258/135581907779497486.
- Donohue, J. M., & Pincus, H. A. (2007). Reducing the societal burden of depression. *Pharmacoeconomics*, 25, 7-24. doi:10.2165/00019053-200725010-00003
- Dowrick, C., Kokanovic, R., Hegarty, K., Griffiths, F., & Gunn, J. (2008). Resilience and depression: perspectives from primary care. *Health*, 12, 439-452. doi: 10.1177/1363459308094419
- Dunkley, J. E., & Bates, G. W. (2014). Recovery and adaptation after first-episode psychosis: The relevance of posttraumatic growth. *Psychosis*, 7, 1-11. doi: 10.1080/17522439.2014.936027
- Feeney, B. C., & Collins, N. L. (2015a). A new look at social support. A theoretical perspective on thriving through relationships. *Personality and Social Psychology Review*. 19, 113-147 doi:1088868314544222.
- Feeney, B. C., & Collins, N. L. (2015b). Thriving through relationships. *Current Opinion in Psychology*, 1, 22-28. doi:10.1016/j.copsy.2014.11.001
- Fernandez, M. E., Breen, L. J., & Simpson, T. A. (2014). Renegotiating identities, experiences of loss and recovery for women with bipolar disorder. *Qualitative Health Research*, 24, 890-900. doi:10.1177/1049732314538550

- Fletcher, D., & Sarkar, M. (2015). Psychological resilience. *European Psychologist, 18*, 12-23. doi:10.1027/1016-9040/a000124
- France, E. F., Ring, N., Thomas, R., Noyes, J., Maxwell, M., & Jepson, R. (2014). A methodological systematic review of what's wrong with meta-ethnography reporting. *BMC Medical Research Methodology, 14*, 119-123. doi:10.1186/1471-2288-14-119
- Gotlib, I. H., & Joormann, J. (2010). Cognition and depression: current status and future directions. *Annual Review of Clinical Psychology, 6*, 285-312. doi:10.1146/annurev.clinpsy.121208.131305
- Hajela, S. (2013). The monster within: Understanding the narratives of depression. *Psychological Studies, 58*, 10-19. doi:10.1007/s12646-012-0164-8
- Hauser, S. T., & Allen, J. P. (2007). Overcoming adversity in adolescence: Narratives of resilience. *Psychoanalytic Inquiry, 26*, 549-576. doi:10.1080/07351690701310623
- Hobson, R. F. (1985). *Forms of feeling: The heart of psychotherapy*. Hove, UK: Routledge.
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593–602. doi:10.1001/archpsyc.62.6.593
- Kessing, L. V., Hansen, M. G., Andersen, P. K., & Angst, J. (2004). The predictive effect of episodes on the risk of recurrence in depressive and bipolar disorders—a life-long perspective. *Acta Psychiatrica Scandinavica, 109*, 339-344. doi:10.1046/j.1600-0447.2003.00266.x
- Kidder, L. H., & Fine, M. (1987). Qualitative and quantitative methods: When stories converge. *New Directions for Program Evaluation, 35*, 57-75. doi:10.1002/ev.1459
- Lafrance, M. N., & Stoppard, J. M. (2006). Constructing a non-depressed self: Women's

accounts of recovery from depression. *Feminism & Psychology*, 16, 307-325.

doi:10.1177/0959353506067849

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199, 445-452.

doi:10.1192/bjp.bp.110.083733

Lewis, L. (2006). Enhancing mentalizing capacity through dialectical behavior therapy skills training and positive psychology. In Allen, J.G. & Fonagy, P. (Eds.) *Handbook of mentalization-based treatment*, (pp. 171-182). Chichester, England: Wiley & Sons.

Malpass, A., Shaw, A., Sharp, D., Walter, F., Feder, G., Ridd, M., & Kessler, D. (2009). “Medication career” or “moral career”? The two sides of managing antidepressants: A meta-ethnography of patients’ experience of antidepressants. *Social Science and Medicine*, 68, 154-168. doi:10.1016/j.socscimed.2008.09.068

Marcus, M., Yasamy, T., van Ommeren, M., Chisholm, D., & Saxena, S. (2008). *Depression: a global health concern*. World Health Organization. Retrieved from: [www.who.int/mental\\_health/management/depression/who\\_paper\\_depression\\_wfmh\\_2012.pdf](http://www.who.int/mental_health/management/depression/who_paper_depression_wfmh_2012.pdf)

Mason, W. A., Rice, M. J., & Records, K. (2005). The lived experience of postpartum depression in a psychiatric population. *Perspectives in Psychiatric Care*, 41, 52-61. doi:10.1111/j.1744-6163.2005.00011.x

McEvoy, P., Schauman, O., Mansell, W., & Morris, L. (2012). The experience of recovery from the perspective of people with common mental health problems: Findings from a telephone survey. *International journal of nursing studies*, 49, 1375-1382. doi:10.1016/j.ijnurstu.2012.06.010

- Michalak, E., Livingston, J. D., Hole, R., Suto, M., Hale, S., & Haddock, C. (2011). 'It's something that I manage but it is not who I am': reflections on internalized stigma in individuals with bipolar disorder. *Chronic Illness*, 7, 209-224.  
doi:10.1177/1742395310395959
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group. (2010). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *International Journal of Surgery*, 8, 336-341. doi:10.1016/j.ijsu.2010.02.007
- Murray, G., Suto, M., Hole, R., Hale, S., Amari, E., & Michalak, E. E. (2011). Self-management strategies used by 'high functioning' individuals with bipolar disorder: from research to clinical practice. *Clinical Psychology & Psychotherapy*, 18, 95-109. doi:10.1002/cpp.710
- NICE (2009). *Depression: Treatment and management of depression in adults*. Clinical Guideline 90. London: National Institute for Health and Clinical Excellence.  
Retrieved from: <https://www.nice.org.uk/guidance/cg90>
- Noblit, G., & Hare, R. (1988). *Meta-ethnography: Synthesising qualitative studies*. Newbury Park, CA: Sage.
- Norcross, J. C., & Wampold, B. E. (2011). What works for whom: Tailoring psychotherapy to the person. *Journal of Clinical Psychology*, 67, 127-132. doi:10.1002/jclp.20764
- Nunstedt, H., Nilsson, K., Skärsäter, I., & Kylén, S. (2012). Experiences of major depression: Individuals' perspectives on the ability to understand and handle the illness. *Issues in Mental Health Nursing*, 33, 272-279.  
doi:10.3109/01612840.2011.653038
- Ormel, J., Vonkorff, M., Oldehinkel, A. J., Simon, G., Tiemens, B. G., & Üstün, T. B. (1999). Onset of disability in depressed and non-depressed primary care patients. *Psychological Medicine*, 29, 847-853. doi:10.1017/S0033291799008600



- Padesky, C. A., & Mooney, K. A. (2012). Strengths-Based Cognitive–Behavioural Therapy: A Four-Step Model to Build Resilience. *Clinical Psychology & Psychotherapy*, 19, 283-290. doi:10.1002/cpp.1795
- Peden, A. R. (1993). Recovering in depressed women: Research with Peplau's theory. *Nursing Science Quarterly*, 6, 140-146. doi:10.1177/089431849300600307
- Peden, A. R. (1996). Recovering from depression: a one-year follow-up. *Journal of Psychiatric and Mental Health Nursing*, 3, 289-295. doi:10.1111/j.1365-2850.1996.tb00128.x
- Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice*, 19, 276-288. doi:10.1037/h0088437
- Richards, D. (2011). Prevalence and clinical course of depression: a review. *Clinical Psychology Review*, 31, 1117-1125. doi:10.1016/j.cpr.2011.07.004
- Ridge, D., & Ziebland, S. (2006). “The old me could never have done that”: How people give meaning to recovery following depression. *Qualitative Health Research*, 16, 1038-1053. doi:10.1177/1049732306292132
- Ridgeway, P. (2001). Restorying psychiatric disability: learning from first person recovery narratives. *Psychiatric Rehabilitation Journal*, 24, 335-343. doi: 10.1037/h0095071
- Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of the New York Academy of Sciences*, 1094, 1-12. doi:10.1196/annals.1376.002
- Schreiber, R. (1996). (Re) Defining my self: women's process of recovery from depression. *Qualitative Health Research*, 6, 469-491. doi:10.1177/104973239600600402
- Scott, J., & Dickey, B. (2003). Global burden of depression: the intersection of culture and medicine. *The British Journal of Psychiatry*, 183, 92-94. doi:10.1192/bjp.183.2.92

- Seery, M. D., Holman, E. A., & Silver, R. C. (2010). Whatever does not kill us: Cumulative lifetime adversity, vulnerability, and resilience. *Journal of Personality and Social Psychology*, 99, 1025-1041. doi:10.1037/a0021344
- Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive Psychology. *American Psychologist*, 55, 5-14. doi:10.1177/0022167801411002
- Seligman, M. E., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist*, 61, 774-788. doi:10.1037/0003-066X.61.8.774
- Shaw, R. L. (2010). Conducting literature reviews. In M. Forrester (Ed.), *Doing qualitative research in psychology: A practical guide* (pp. 40-49). London, England: Sage Publications.
- Shaw, R. L. (2012). Identifying and synthesizing qualitative literature. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 9-22). Chichester, England: John Wiley & Sons Ltd
- Skärsäter, I., Dencker, K., Bergbom, I., Häggström, L., & Fridlund, B. (2003). Women's conceptions of coping with major depression in daily life: a qualitative, salutogenic approach. *Issues in Mental Health Nursing*, 24, 419-439. doi:10.1080/01612840305313
- Skärsäter, I., Dencker, K., Häggström, L., & Fridlund, B. (2003). A salutogenetic perspective on how men cope with major depression in daily life, with the help of professional and lay support. *International Journal of Nursing Studies*, 40, 153-162. doi:10.1016/S0020-7489(02)00044-5
- Slade, M., Adams, N., & O'Hagan, M. (2012). Recovery: past progress and future challenges. *International Review of Psychiatry*, 24, 1-4. doi:10.3109/09540261.2011.644847

- Spaniol, L., Bellingham, R., & Cohen, B., (2003). *The recovery workbook: II. Connectedness*. Boston, MA: Boston University Centre for Psychiatric Rehabilitation.
- Steen, M. (1996). Essential structure and meaning of recovery from clinical depression for middle-adult women: a phenomenological study. *Issues in Mental Health Nursing*, 17, 73-92. doi:10.3109/01612849609034998
- Steinert, C., Hofmann, M., Kruse, J., & Leichsenring, F. (2014). Relapse rates after psychotherapy for depression—stable long-term effects? A meta-analysis. *Journal of Affective Disorders*, 168, 107-118. doi:10.1016/j.jad.2014.06.043
- Tedeschi, R. G., & Calhoun, L. G. (2004). "Posttraumatic Growth: Conceptual Foundations and Empirical Evidence". *Psychological Inquiry*, 15, 1-18. doi:10.1207/s15327965pli1501\_01
- Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., & Barker, K. (2014). Meta-ethnography 25 years on: challenges and insights for synthesising a large number of qualitative studies. *BMC Medical Research Methodology*, 14, 80. doi:10.1186/1471-2288-14-80
- van Vliet, K. J. (2008). Shame and resilience in adulthood: A grounded theory study. *Journal of Counselling Psychology*, 55, 233–245. doi:10.1037/0022-0167.55.2.233
- Vidler, H. C. (2005). Women making decisions about self-care and recovering from depression. *Women's Studies International Forum*, 28, 289-303. doi:10.1016/j.wsif.2005.04.014
- Woods, M. D., Kirk, M. D., Agarwal, M. S., Annandale, E., Arthur, T., Harvey, J., ... & Dixon-Woods, M. (2005). Vulnerable groups and access to health care: a critical interpretive review. *National Coordinating Centre NHS Service Delivery Organ RD*

(*NCCSDO*) Retrieved from:

[http://www.netscc.ac.uk/netscc/hsdr/files/project/SDO\\_FR\\_08-1210-025\\_V01.pdf](http://www.netscc.ac.uk/netscc/hsdr/files/project/SDO_FR_08-1210-025_V01.pdf)

# Appendix A

Table 4  
*Summary of Papers and Appraisal Process*

	1: aims clear?	2: qualitative method	3: design	4: recruitment strategy	5: data collection	6: adequate reflexivity	7: ethical issues	8: data analysis rigorous	9: clarity of findings	10: value of research	11: quality
1. Peden (1993)	✓	✓	✓	✓	✓	x	x	✓	✓	✓	SAT
2. Peden (1996)	✓	✓	✓	✓	✓	x	x	✓	✓	✓	SAT
3. Steen (1996)	✓	✓	✓	? (not described)	✓	?	✓	✓	✓	✓	SAT
4. Schreiber (1996)	✓	✓	✓	?	✓	x	x	✓	✓	✓	SAT
5. Chernomas (1997)	✓	✓	✓	✓	✓	✓	✓	? lack of detail in reporting of analysis method	✓	✓	?
6. Skarseter, Dencker, Bergbom, Hag (2003)	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	SAT
7. Skärsäter, Dencker, Hägström, & Fridlund (2003)	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	SAT
8. Vidler (2005)	✓	✓	✓	✓	✓	x	x	✓	✓	✓	SAT

Table 4 (continued)

1: aims clear?	2: qualitative method	3: design	4: recruitment strategy	5: data collection	6: adequate reflexivity	7: ethical issues	8: data analysis rigorous	9: clarity of findings	10: value of research	11: quality
9. Lafrance & Stoppard (2006)	✓	✓	✓	✓	x	x	✓	✓	✓	SAT
10. Ridge & Ziebland (2006)	✓	✓	✓	✓	x	✓	✓	✓	✓	SAT
11. Dorwick, Kokanovic, Hegarty, Griffiths, & Gunn (2008)	✓	? insufficient reporting.	✓	✓	x	✓	? insufficient reporting of analysis method	✓	✓	?
12. Chuick, Grenfeld, Shepard, Cochran, & Haley (2009)	✓	✓	✓	✓	✓	✓	✓	✓	✓	SAT
13. Michalak, Livingston, & Hole (2011)	✓	✓	✓	✓	x	✓	✓	✓	✓	SAT
14. Murray, Suto, Hole, Hale, Amari, & Michalak, (2011).	✓	✓	✓	✓	x	✓	✓	✓	✓	SAT

Table 4 (continued)

	1: aims clear?	2: qualitative method	3: design	4: recruitment strategy	5: data collection	6: adequate reflexivity	7: ethical issues	8: data analysis rigorous	9: clarity of findings	10: value of research	11: quality
15. Nunstedt, Nilsson, Skarsater, & Kylan (2012)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	SAT
16. Hajela (2013)	✓	✓	✓	✓	✓	x	✓	? lack of detail in reporting of analysis	✓	✓	?
17. Fernandez, Breen, & Simpson (2014)	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	SAT

## Appendix B

### CASP: 10 Questions to help make sense of qualitative research

#### Screening questions:

1. Was there a clear statement of the aims of the research?

*Consider:*

*What the goal of the research was*

*Why is it important*

*Its relevance*

2. Is a qualitative methodology appropriate?

*Consider:*

*If the research seeks to interpret or illuminate*

*the actions and/or subjective experiences of research participants*

#### Detailed Questions:

3. Was the research design appropriate to address the aims of the research?

*Consider:*

*If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?*

4. Was the recruitment strategy appropriate to the aims of the research?

*Consider:*

*If the researcher has explained how the participants were selected*

*If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study.*

*If there are any discussions around recruitment (e.g. why some people chose not to take part)*

5. Were the data collected in a way that addressed the research issue?

*Consider:*

*If the setting for data collection was justified*

*If it is clear how data were collected*

*If the researcher has justified the methods chosen*

*If the researcher has made the methods explicit*

*If methods were modified during the study.*

*If so, has the researcher explained how and why?*

*If the form of data is clear (e.g. tape recordings, video material, notes etc.)*

*If the researcher has discussed saturation of data*

6. Has the relationship between researcher and participants been adequately considered?

*Consider:*

*If the researcher critically examined their own role, potential bias and influence during: Formulation of the research questions, data collection, including sample recruitment and choice of location*

*How the researcher responded to events during the study*

*If they considered the implications of any changes in the research design*



7. Have ethical issues been taken into consideration?

*Consider:*

*If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained*

*If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)*

*If approval has been sought from the ethics committee*

8. Was the data analysis sufficiently rigorous?

*Consider:*

*If there is an in-depth description of the analysis process*

*If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?*

*Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process.*

*If sufficient data are presented to support the findings*

*To what extent contradictory data are taken into account*

*Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*

9. Is there a clear statement of findings?

*Consider:*

*If the findings are explicit*

*If there is adequate discussion of the evidence both for and against the researcher's arguments*

*If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)*

*If the findings are discussed in relation to the original research question*

10. How valuable is the research?

*Consider:*

*If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature?*

*If they identify new areas where research is necessary*

*If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*

## Appendix C

Table 5

### *Summary of Themes Development*

Overarching category	Second order construct	Translation of second order construct (summary definition)	Paper containing second order construct
Process, non-linear which includes acceptance of pain	Work over time	<b>Conceptualization of recovery</b> Recovery as a process which is ongoing and involves periods of difficulty	1, 2, 3, 6, 10, 16, 17
	Non-linear		
	Turning point		
	A process, dynamic, occurring in non-serial order		
	Recovery as a process – moving back and forth all the time		
	Recovery takes much time and involves relapses		
	The journey of feeling alive		
	Slow – mindfulness of good and bad days and bearing with		
	Maintaining balance		
	Self monitoring		
	Accepting		
	Growth from crisis		
	Recovery as a growth		
	Depression as a growth experience		
A gain over pre- depressed self	Personal growth	Recovery is about a gain rather than a mere return to baseline functioning	1, 2, 3, 4, 6, 9, 10, 16
	Transformation in recovery		
	Recovery as increase over baseline		
	Recognition of changing what had led to depression		

Table 5 (continued)

Overarching category	Second order construct	Translation of second order construct (summary definition)	Paper containing second order construct
Naming recovery.	Seeing with clarity Need for a language of recovery Insight into processed of recovery Making use of understanding	Understanding the self as 'in recovery'.	1, 2, 3, 4, 5, 10, 15, 17
		<b>Developing a recovery 'tool kit'</b>	
Choosing	Actively involved in treatment decisions Exercising choice over treatment options Individual tailored to the self	Application of choice in what interventions to use and when	1, 2, 6, 8, 10
Utilizing external resources	Using professional and lay help The importance of 'fit' between personal and professional Seeking information Naming/ identifying depression Being unburdened Receiving information Sources of help to increases self-insight Help seeking Developing tools of recovery Strengthening understanding with information and knowledge Safety Trusting the knowledge of others Family and friends' support	External resources including both people (professional and lay) as well as practical resources, such as information. The quality of relationship was integral to accessing help from other people	1, 2, 3, 4, 6, 7, 10, 12, 14, 15, 16

Table 5 (continued)

Overarching category	Second order construct	Translation of second order construct (summary definition)	Paper containing second order construct
Personal strategies	Using skills Trial and error Self as healer Personal self-help strategies Restoring one's own health Using one's own resources Planning Self-healing Managing Learning how to relate the world (removing factors which had contributed to depression) Building on personal strengths Expanding positive emotions Self-care Self-monitoring Enacting a personal plan Trusting own understanding	Includes developing and recognizing internal resources as well as planning and managing wellbeing	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17
Talking about depression	Telling my story Finding a sympathetic ear Talking to others Being confirmed Putting problems into words Confiding in family or friends	<b>Turning-to-relationship</b>  Sharing the experience of depression which in turn facilitates developing relationships	1, 2, 3, 5, 6, 7, 13, 15, 16

Table 5 (continued)

Overarching category	Second order construct	Translation of second order construct (summary definition)	Paper containing second order construct
Selective disclosure.	Controlling information Revealing versus concealing Selective choice of who to talk to Choosing non-judgmental others Judicious disclosure	Although sharing the depressed experience was important, discretion was exercised over what to share and who with	3, 4, 5, 7, 14, 15, 17
Being-in-relationship	Turning to relationship Struggling within (about turning to relationships) Acceptance and belonging Interacting with others Feeling safe Being confirmed Being part of a fellowship (leading to greater self-reliance) Experiencing concordance Seeking social support Increasing affectional bonds Yielding to significant others Connecting with others Identifying with others Turning to positive relationships and ending or limiting negative relationships Discarding the 'not me' and renegotiating relationships Gaining space for oneself Discarding ingrained roles Letting go of self-sacrifice Giving up unsustainable roles Changing patterns and developing an authentic self	Choosing to actively live in relationship with others which in turns enables connection, validation and a sense of relational safety	1, 2, 3, 4, 5, 6, 7, 8, 11, 14, 16, 17
Re-negotiating relationships.		Relationships are problematic, to achieve being-in-relationships, problem of relating needed to be addressed	1, 3, 4, 5, 6, 7, 8, 9, 10

Table 5 (continued)

Overarching category	Second order construct	Translation of second order construct (summary definition)	Paper containing second order construct
Determination.	Determination and personal choice to engage in recovery Self as healer Assuming responsibility for depression and recovery Breaking free Choice Monitoring and taking action (to apply recovery skills)	Where the determination to recover is crystalized as active intent and developed through personal action	1, 2, 3, 4, 5, 9, 10, 16, 17
Alones – Togetherness	The independent patient Acting as own agent Autonomy in decision making Concordance Renegotiating relationships Self versus other agency	The cultivation of relationships which both supported but also emancipated self	3, 6, 7, 8, 9, 14
The empowered self	Feeling involved Taking control Being part of society Increased self-control Empowerment Regaining command over everyday structure Increasing ‘self’ agency and reducing ‘other’ agency Agency Taking control and increased autonomy	Recovery leading to increased exercise and experience of the agentic self	2, 3, 6, 7, 8, 10, 16, 17

Table 5 (continued)

Overarching category	Second order construct	Translation of second order construct (summary definition)	Paper containing second order construct
Stigma	Learning about stigma Experiences of stigma and expectations Negative self and other judgment	<b>Stigma</b> Stigma as both internalized and also experienced from others	3, 4, 6, 7, 8, 12, 13
Personal resilience	Successes during recovery reinforce the process of recovery Weathering a crisis Increased self-esteem Owning the missing part of myself Learning and being strengthened Enhanced self-reliance Awareness of greater coping Discovering the different and perhaps unknown qualities of self that potentially lay beyond depression Personal medicine and ordinary magic	<b>Personal Resilience</b> Developed of resilience through adversity in the themes described above.	1, 2, 3, 4, 6, 7, 10, 11

## **Part Two: Research Report**

### **A Qualitative Study Exploring Engagement in the Early Stages of Psychotherapy for Depression**





## **Abstract**

**Objective.** The aim of the present study is to explore client activities associated with the development of engagement in the early stages of two psychotherapies for moderate to severe depression delivered within primary care.

**Design.** Sixteen therapy sessions representing sessions one and two, of patients receiving either Cognitive Behavioural Therapy (CBT: n=4) or Counselling for Depression (CfD: n=4) were audio recorded. Therapists were trained in either CBT (n=4) or CfD (n=3).

**Method.** Template Analysis was used to analyse 16 transcripts of therapy sessions.

**Results.** Three over-arching themes were developed. Firstly, participants learned and adapted to the modality. This included an initial period of orientation, learning the ropes, finding a focus, and accepting the limits of what could be addressed. Secondly, clients learned to adapt to the therapist. This included developing and maintaining a relationship, investing in the therapist, and working with the therapist's lead. Thirdly, clients needed to flexibly exercise agency through: setting boundaries and directing a focus, managing therapist contributions, and expressing relational needs. Where clients could not effectively exercise agency engagement became compliance.

**Conclusion.** The findings emphasized the importance of client-initiated activity and the exercise of agency in successful therapeutic engagement.

### **Practitioner Points:**

- Practitioners should work to recognize the preferences and competences which clients bring to therapy and actively work with these to provide a tailored therapeutic response.
- Client learning and understanding of therapy processes should be actively supported.

**Research Points:**

- The present study examined two psychotherapies for depression. Further research is needed to establish if the processes described apply to a wider range of therapies and client groups.
- Engagement is inherently reciprocal and further research needs to examine the interaction of therapist and client factors.

## **Introduction**

The availability of psychological treatments for depression has increased markedly in recent years, supported by an expanding evidence base (NICE, 2009). While psychological therapies for depression are considered effective (Cuijpers, van Straten, Warmerdam, & Anderson, 2008), overall recovery rates remain relatively low, with relapse common (Steinart, Hofmann, Kruse, & Leichsenring, 2014). Improving outcomes is a multifactorial problem but increasing client engagement, particularly in the early stages of therapy, is recognised as pivotal (Simon et al., 2012).

Poor engagement can impact on the course and outcome of therapy at a number of levels but is most obvious when clients prematurely discontinue from therapy (Hill, 2005). In a recent meta-analysis, Cooper and Conklin (2015) found an average of 19.9% dropouts from Randomised Control Trials of psychological therapies for depression; these findings are comparable to the 19.7% found by Swift and Greenberg (2012) in their meta-analysis of dropout rates from a range of modalities and presenting problems. However, despite a commonality in overall levels of dropout between these two reviews, both meta-analyses found high levels of heterogeneity between studies. In a subsequent re-analysis of their data, Swift and Greenberg (2014) found that drop-out rates were highest for depressed clients receiving cognitive behavioural therapy and analysis system psychotherapy (23%), and lowest for depressed clients receiving integrative approaches, with only a 10% dropout rate. Swift and Greenberg (2014) were unable to find any systematic differences in other variables that accounted for the difference in dropout rates and concluded that depressed clients benefited from the blended engagement techniques found in integrative approaches, suggesting that this enabled therapists to more flexibly tailor their approach to the needs of individual clients.

While problems with engagement may occur at any point, the early stages of therapy may function as a critical period during which the highest levels of dropout occur. In a review of early studies, Barrett, Chua, Crits-Christoph, Gibbons, and Thompson (2008) found approximately half of all dropouts occurred by the third session (Hiler, 1958) with upwards of 20% occurred at the first session (Brandt, 1965; Baekeland & Lundwall, 1975). The findings have been replicated by a number of later studies (e.g. Bados, Balaguer & Saldaña, 2007).

Support for the importance of early engagement processes also comes from dose-response models of treatment, where research suggests that the initial stages of therapy may be particularly important for achieving improvements in subjective wellbeing and “remoralization” (Lueger et al., 2001). While alternative lines of research have argued for a more complex and individualized response to treatment length the significance of early engagement in supporting subsequent treatment progress remains (Barkham et al., 2006; Stiles, Barkham, & Wheeler, 2015; Owen et al., 2015).

Approaches to increasing therapeutic engagement have been considered from the perspective of the therapist (e.g. Wampold, 2011). However, a growing body of research suggests that attention needs to be redirected towards the role of the client in therapy outcomes. For example, qualitative accounts of recovery from depression suggests that the exercise of choice by individuals experiencing depression plays a significant part in the determinants of recovery (e.g. Skärsäter, Dencker, Bergbom, Häggström, & Fridlund, 2003), while a further body of research has begun to theorize the active role of the client (Bohart & Tallman, 2010). Despite the increased recognition of the client’s role in therapeutic outcomes, how clients engage in therapy has received limited research and theoretical attention (Holdsworth, Bowen, Brown, & Howat, 2014).

Hill (2005) argued that clients’ engagement (referred to as involvement) works in

tandem with therapist techniques and the developing therapeutic relationship to create the conditions necessary for therapy to take place. Hill (2005) conceptualized this as happening over four stages: initial impressions, beginning therapy, tasks of therapy and termination. Hill (2005) suggests that client activities change at each stage, moving from an initial focus on trusting, through storytelling and engaging in the tasks of therapy, before finally processing relationships and planning for the future. However, beyond broadly sketching primary stages, Hill (2005) does not describe in detail the activities which clients use to engage in therapy.

In an attempt to readdress the balance, Morris, Fitzpatrick, and Renaud (2014) reviewed the limited engagement literature and proposed a pan-theoretical model of client engagement which they defined as the client's active and concrete participation or involvement in the process of therapy. It is composed of three dimensions: (i) behavioural participation in the tasks of therapy, (ii) exploring and reporting on thought processes, and (iii) experiencing and examining emotions and sensations. Each element of the model can be defined in terms of intensity and clients may be more or less involved in different dimensions simultaneously. While specific manifestations of each dimension may vary by modality, Morris et al. (2014) propose that the processes they represent are common across modalities.

Morris et al. (2014) acknowledge a conceptual overlap between the process of engagement and the working alliance. Bordin's (1979) conceptualisation of the alliance comprises the collaborative agreement between therapist and client on the tasks and goals of therapy and the formation of a relational bond. The client is necessarily engaged in therapy in order to achieve agreement over tasks and goals. However, as Morris et al. (2014) argue, it is theoretically possible for aspects of engagement to be achieved without the corresponding development of a working relationship. In an attempt to populate their

model, Morris et al. (2014) conducted a Delphi poll of clinicians from a range of therapeutic orientations. Clinician responses supported the above tripartite definition of engagement, offering a range of possible markers of client engagement as observable from the therapist's perspective.

Morris et al.'s (2014) model of engagement offers a tentative 'bare bones' starting point for enquiry, but they highlight the need for further research to understand and illustrate the detailed process which clients use to engage in therapy. The researchers also acknowledge the absence and need for research which privileges an understanding of engagement from the client's perspective.

The present study proposes to address this need by exploring the processes of engagement in therapy for depression from the client's perspective through qualitative enquiry. Qualitative enquiry is particularly suited to the rich exploration of participant experience in order to support the development of novel understandings, which may help with the process of theory building and identification of factors which might be subsequently tested quantitatively (Glasser & Strauss, 2009).

The aim of this study is therefore to examine client activities associated with the process of engagement in the early stages of therapy for depression. Following Morris et al.'s (2014) argument that engagement processes are common across modalities, and the findings of Swift and Greenbergh (2014) that depressed clients achieved the best engagement from an integrative approach, common processes of early engagement will be explored through two contrasting therapeutic modalities: Cognitive Behaviour Therapy (CBT) and Counselling for Depression (CfD). Within the UK, CBT is the first line treatment choice for depression as recommended by NICE (2009) and has become widely available through the expansion of the Improving Access to Psychological Therapies (IAPT) service. In recognition that some clients do not respond to CBT, Counselling for

Depression (CfD), a manualized variant of Rogerian Person-Centred Counselling, is also offered. While other approaches are not excluded from provision, taken together CBT and CfD account for the majority of NHS patient experiences of psychological treatment for depression within primary care at present.

## **Method**

### **Design and Procedure**

A qualitative approach using Template Analysis (TA; King, 2004) was employed. TA is a form of thematic analysis based on generating codes from qualitative data from which a ‘template’ is developed which demonstrates the relationship between hierarchically organised themes. As Brooks and King (2012) describe, TA allows a flexible exploration of the data and neither requires nor is limited to a predetermined number of hierarchical levels. Themes may be both interpretative and descriptive and may be developed within and between datasets. King (2004) outlines a number of advantages of TA over Grounded Theory (Strauss & Corbin, 1994) and Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009). The principle advantage of TA to the present study was the provision to develop a tentative *a priori* template, but without limiting subsequent analysis to these themes, allowing a full and responsive immersion in the data. TA has previously been successfully used to support theory and model development (McCluskey, Brooks, King, & Burton, 2011; Brooks & King, 2012). “King (2012) states that TA does not come with prescribed epistemological underpinnings, but can be used with a range of epistemological positions. King (2012) expands this to argue that TA can be used at any point along that continuum from realism to contextual constructivism. Care should be taken that the way TA is applied is consistent with the stated assumptions of the study. While inherently flexible as a form of thematic analysis, King (2012) acknowledges that TA tends not to lend itself to radical relativist approaches applied to the fine grained



analysis of language, such as within conversation or discourse analysis.”

Within the continuum of positions, which span naïve realism to radical constructivism, the present research adopts a critical realist perspective. Critical realism argues for the operation of an independent, material reality but acknowledges that our understanding of it is always relative to a culturally mediated act of interpretation (Sayer, 2000).

The study was nested within a parent trial, the “Pragmatic, Randomised Controlled Trial assessing the non-Inferiority of Counselling and its Effectiveness for Depression” (PRaCTICED). The overall trial aims to investigate the clinical effectiveness of Counselling for Depression (CfD) in comparison with Cognitive Behavioural Therapy (CBT) for clients with moderate to severe depression. The trial is being conducted within a primary care IAPT service.

CfD is a variant of Person-Centred therapy developed for the treatment of depression. Consistent with person-centred therapies, CfD assumes that people have within themselves the capacity to heal. The role of the counsellor is to support this natural tendency through the therapeutic relationship, which should offer an experience of “unconditional positive regard” (Rogers, 1951). Within CfD, depression results from difficulties experiencing primary emotions and ways of constructing the self (Hill, 2011). Change takes place as the individual becomes more open to their experience and aware of their beliefs.

CBT (Beck, Rush, Shaw, & Emery, 1979) works to change the cognitions and behaviours thought to maintain depression, using a range of techniques and skills building exercises. The approach is highly structured and involves a period of assessment and formulation, followed by goal setting and behavioural scheduling. The therapist works collaboratively with the client to identify and change the cognitions thought to maintain

depression. For both treatment types a maximum of 20 sessions is offered.

Audio recordings of therapy sessions one and two for each participant were collected as part of the parent trial and made available for the present analysis. For both treatment types, session one covers introducing the clients to a range of service level and procedural information, which may take up a significant part of the session. Session two allows a full therapeutic focus to develop.

## **Measures**

In order to contextualise the sample, measures of depression were collected as part of the parent trial. The Beck Depression Inventory-II, (BDI; Beck, Steer, & Brown, 1996) is comprised of 21 items. The intensity of each item is scored from 0-3. Scores are aggregated to an overall score, with higher scores indicating greater severity of depression, on a range from 0 to 63. The BDI-II has good internal consistency (alpha) 0.86 (Beck, Steer, & Garbin, 1988).

## **Participants**

Clients initially presented in primary care and were referred by their GP to the local IAPT service for depression. Four CBT and three CfD therapists were recruited to the trial on a voluntary basis, all from the same regional IAPT service. CBT therapists had completed training in High Intensity CBT for anxiety and depression accredited by the British Association of Behavioural and Cognitive Psychotherapies (BABCP) and received a refresher workshop prior to participation in the trial. CfD therapists were recruited with an existing qualification in Counselling accredited by the British Association for Counselling and Psychotherapy (BACP) and were trained to a predetermined levels in CfD by the PRaCTICED trial following a curriculum developed by BACP. Fidelity to both models was assessed by PRaCTICED, through the rating of selected audio-taped recordings of

therapy sessions. The first eight client participants entering the parent trial were used in the present study; they were randomly allocated to either the CfD or CBT treatment group. The clients comprised three men and five woman, aged between 19 and 60 years. Nine identified as White British, the ethnicity of one participant was not known. Three were not in employment, and five were employed. All clients met the BDI-II criteria for moderate to severe depression.

Table 1  
*Client characteristics.*

Client*	Age	Gender	Employment Status	BDI-II	Therapist*
<i>CBT group</i>					
Becky	27	F	Not employed	47	Peter
Jamie	45	M	Not employed	28	Leslie
Iris	51	F	Employed	36	Lyn
Tracy	19	F	Employed	45	Fran
<i>CfD group</i>					
Darren	60	M	Employed	26	Penny
Rachel	24	F	Employed	35	Don
Roy	19	F	Employed	45	Sybill
Rob	57	M	Unemployed	22	Penny

\*To maintain confidentiality pseudonyms have been employed to refer to clients and therapists

### **Data collection**

Therapists audio-recorded their therapy sessions. Prior consent had been obtained from clients when they completed the trial's consent form. Therapists were allocated numerical keys to identify themselves and clients on the audiotape. Audio recordings were transcribed verbatim. Outcome measures were completed by clients as part of their initial session, consistent with routine practice within the IAPT service and the trial requirements.

## **Analysis**

Analysis of transcripts followed procedures developed by King (2004). An initial template based on *a priori* themes suggested by Morris et al.'s (2014) model was developed first. This template used three higher level themes: 'behavioural participation'; 'cognitive exploration and reporting' and 'experience and examine emotions'. Behavioural included "work outside session" and 'work within session'. Cognitive included 'exploring thoughts'; 'questioning thoughts' and 'changing thoughts'. Emotional included 'experiencing emotions'; 'naming emotions'; and 'accepting emotions'. The first set of transcripts (sessions one and two from a CBT and CfD therapy) were read and the audio recordings listened to. The initial template was applied, modified and adapted. This process continued with each successive reading of subsequent transcripts, which were read alternating between CBT and CfD, with sessions one and two coded together. At the end of the first round of coding, the template was substantially revised and an alternative organisational structure developed from that proposed by Morris et al. (2014).

The coding process was repeated in a similar fashion, with the template revised and developed as it was applied to each new transcript. No new codes emerged toward the end of the process and therefore saturation was assumed. The template was then reviewed and finalized before being re-applied to the data set.

## **Quality Control**

The researcher followed quality control procedures recommended for template analysis by King (2004). Transcripts were systematically checked for accuracy against audio recordings by the researcher. Equal attention was paid to recordings and transcripts during coding. The credibility of the analysis was ensured using a system of peer review. Three researchers applied the final template and independently coded six transcripts. This quality control procedure followed recommendations by King (2012) when conducting TA.

Similarities and differences were discussed and the template revised where necessary and a final set of themes agreed upon. An example extract from one transcript is included in Appendix D to illustrate the coding process and extracts from several transcripts for one segment of the final template.

### **Reflexivity**

Reflexivity involves considering those aspects of the researcher that may influence their interpretation of the data. Haynes (2012) notes that the reflexive process goes beyond observation reflection to consider the complex relationship between how knowledge is produced, the process of production and the impact of the person of the producer. In order to remain aware of this process, the researcher kept log notes of each stage of the research process, describing the researcher's interests, values, assumptions, and the role played by emotional reactions in framing the response to the data and individual participants and choices made in coding. Issues of note included how the researcher's role as a trainee therapist and her wider interests and experiences influenced the analysis process. These observations also informed discussion with the independent coders as part of the quality control process and aided a robust reflexive questioning of the analysis process.

### **Ethics**

Ethical and governance approval from the University of Sheffield and host NHS trust were given under the auspice of the parent trial. Participant consent was also obtained by the PRaCTICED trial. A copy of ethics approval is given in Appendix E and copies of consent and participant information documents is given in Appendix F. The direct wellbeing of trial participants and issues of risk were within the domain of responsibility for the parent trial. The primary ethical issues encountered in the present study related to ensuring the anonymity and confidentiality of the audio recordings received from the

PRaCTICED trial. Rigorous management of data, in line with data protection principles were applied to the storing, handling and movement of data in both audio and written form.

## Results

The following analysis examined 16 therapy session transcripts of eight clients in order to understand what clients did to engage in the early stages of therapy. Three top-level themes, ‘learning and adapting to therapy’, ‘adapting to the therapist’ and ‘exercising agency’, were developed to represent these processes. Each top-level theme has further levels of coding as summarised in Table 2. The third theme, ‘exercising agency’, can be considered an integrative theme, which informs both ‘learning and adapting to therapy’ and ‘adapting to the therapist’.

Table 2.  
*Summary of Themes*

First Level	Second Level	Third Level
1. Learning and adapting to the therapy	1.1 Initial orientation 1.2 Learning the ropes 1.3 Framing the problem 1.4 Accepting limitations	
2. Adapting to the therapist	2.1 Developing and maintaining a relationship 2.2 Investing in the therapist 2.3 Working with the therapist’s lead	2.3.1 Following the therapist 2.3.2 Struggling but trying 2.3.3 Co-constructing
3. Exercising agency	3.1 Setting boundaries and directing a focus 3.2 Managing therapist contributions 3.3 Expressing relational needs 3.4 Loss of Agency	3.2.1 Selectively responding and discounting 3.2.2 Disagreeing

## 1. Learning and Adapting to Therapy

**1.1 Initial orientation.** The initial stage of therapy required clients attend to considerable information, including contractual and organisational protocols contingent upon providing informed consent, service requirements, and therapist introductions. Therapists varied widely in the level of detail they provided and how much of the first session was given over to these activities. For example, Rachel was advised by her therapist that around 40 minutes would be given over to this task. The rigour which her therapist applied ensured that Rachel fully understood contractual matters, but also required that she attend to large amounts of information. This limited her opportunity to give her therapist information about her difficulties linked to Tourette's, until an involuntary verbal tick acted as an interruption and she then explained her difficulties with conversation:

Don: I'm probably will be speaking maybe 40 minutes or something like that, ok?

Because we need to do five things; first I need to introduce myself; secondly we need to talk about –

Rachel: (interrupts, noise, verbal content not discernible) I've got Tourette's, so 'fuck off', 'chicken' anything with f, anything with b, it's not me.

Don: Oh, ok.

Rachel: I nearly – just because I was about to do it I was like – I thought I'd tell you before I do it, so.

Equally, too little information could impact adversely on engagement by limiting the client's early understanding of both process and contractual issues, as in the case of Darren and his therapist, Penny, who found themselves at the end of session one without having completed mandatory outcome measures:

Darren: I'll do it next time I come here, first of all, before I start blabbering on, sorry.

Penny: Oh no no we've talked about a lot, I imagine it's all still, it was really nice to meet you.

While there was no one 'right' balance, some encounters were characterised by an exchange which suggested that sufficient detail and understanding had been achieved, such as in the following example of Rob and his therapist, Penny. The quote comes at the end of a conversational exchange in which Penny has outlined the main issues in the first ten minutes of a CfT session:

Penny: "Yes, absolutely, and it's a way of starting that, but then in subsequent sessions I'll just ask you to do that quickly at the start of the session."

Rob: "Yes, absolutely fine."

Penny: "Is there anything that you would like to ask me before we sort of get down to that?"

Rob: "Not really, because I think it's been very well explained in the correspondence that I've had and the talks that I've had with various people. And you've explained it really fine now, so."

For some clients assimilating information, which characterised the initial therapeutic meeting, appeared more challenging, as in the initial encounter between Jamie and his therapist. In the following extract, Leslie (therapist) had just finished giving a comprehensive and lucid explanation describing CBT, including a standard explanation of risk and confidentiality:

Leslie: "So, you do need to know that, if you for instance said to me today, I've already decided what I'm gonna do and when I'm gonna do it and how I'm gonna do it, we are required by law to save somebody's life in the ultimate but, you know,



it's never ever happened and we'd never sort of just go behind your back and start doing things, we always discuss things together but you do need to know that, in the ultimate, we're required to save somebody's life."

Jamie: "How would that work? I'm just curious cos if I say, if I said to you now, right I've got a plan, gonna go out and kill myself. And the session ended, and you said OK, bye, see you later."

Leslie: "Yeah, I wouldn't be wanting to let you leave the surgery, I'd be wanting to ask you to go and talk to your doctor straight away."

Jamie: "OK, I just wondered how it worked."

The tone of the exchange was tense and sounded somewhat confrontational. It was in marked contrast to the ease between Rob and Penny as seen in the previous therapy extracts. Later in the session, Jamie revealed that he has experienced suicidal thoughts, in response to a standard question on outcome measure for depression, at which point the therapist conducted a full risk assessment. Initial orientation affected engagement on a number of levels and clients may need the opportunity to convey important initial information while also listening too and retaining their therapist's explanations, and for some these routine processes could touch on emotive areas linked to underlying distress.

**1.2 Learning the ropes.** In order to engage further, clients needed to learn the activities, principles and rationale which informed the therapy. Therapists varied in the degree to which they provided an explanation of the principals informing the treatment type and explicit instructions on the 'tasks' involved in participating. Clients also varied in the ease with which they learned and understood what was required of them. In the following

example, Becky demonstrated a pre-existing understanding of the basic rationale informing CBT:

Peter: “So shall I explain a bit about CBT and what that would involve yeah?”

Becky: “Aha, I know er, with CBT looks at like the behaviour side of depression, rather than just like with a counsellor, talking about problems and stuff like that.

Peter: “Yeah, that, that’s a good summary yeah, so.”

In some instances, it was apparent that clients offered engagement without yet knowing the reason for an activity. In the following exchange, Iris described her experience of completing weekly outcome measures with a previous therapist in the absence of understanding why she was doing so and compares it to her present level of understanding:

“[When] I understand what’s happening, then I’m happy with it. But nobody explained anything before. I was just like – it just went over my head, because I didn’t understand what it was about, because nobody ever told me and – I came all those times, and I never knew anything about them, and – I mean, I filled that one in wrong, about the social thingy and what have you, and now you’ve explained to me, I think, yes, you are right.”

For some clients, the difficulty of learning how to participate in therapy could be likened to learning a new culture, in which the rules of engagement are often implicit and learned experientially. In the following extract, Darren described to his therapist, Penny, his anxiety as he assimilated his role within counselling and acculturated to speaking and talking about himself in a style which he perceived to be at variance with his identity:

Penny: “So how do you feel about being here?”

Darren: “Strange.”

Penny: “Strange”

Darren: “Strange, very strange, but erm, I suppose I suffer from er, that symptom, you know, can sort it ourselves.”

The struggle to provide what was required of him and the extent to which this challenged his existing way of being, ‘feels like being sick’:

“I feel like I feel like I’m trying to be sick but you, you can’t but then all of a sudden, you just don’t wanna burden people with this, you don’t do you?”

“Not knowing” what to say is repeated several times by Darren during both sessions, as he engaged with the process of therapy and making sense of his experience,

“(it is) embarrassing it really is, it really is, and trying to concentrate and g- and gather your thoughts for certain is- it’s impossible, it’s so foreign to me, my own mind is so foreign to me, I don’t know.”

For Darren, it could be argued that learning about therapy needs the ability to tolerate periods of uncertainty and anxiety as he began to understand what is required.

**1.3 Framing the problem.** Framing the problem involved clients choosing a focus for therapy and applying a modality-specific interpretation of their experience. For some, this aspect of engagement was more easily achieved than others. In the following example, the difficulty of agreeing a therapy focus became clear in a discussion between Iris and her therapist about diagnostic categories:

Iris: “So I’m a bit confused now, as to what’s what. Because I never recognised that I had depression, because I could deal with anything. But I did realise that the social phobia thing was exactly what is happening. But this week, it’s swayed more towards the other. So, I’m a bit muddled now.”

After a period of further discussion, Lyn suggested an initial focus:

Lyn: “Let’s start with this low mood, because you’re overwhelmed, it’s getting you down, you look tired.”

Iris: “I’m exhausted.”

Learning to frame their difficulties within the modality offered a further level of learning and appeared to happen more easily where there was a sympathetic fit with clients’ existing understanding. In the following example, Tracey and her therapist, Fran, applied a simple CBT formulation in their initial session. The formulation model, based on links between cognitions, behaviours and feelings, was congruent with Tracey’s existing insight:

Fran: “If all these arrows are a bit linked, kind of, we’ve got these unhelpful thoughts that impact your feelings, your feelings then drive your behaviours and sometimes that helps a bit in the short term. But in the long term those thoughts come back and then you feel really tired so you try really hard to distract yourself (yes). What sense does that make?”

Tracey: “Um, that makes a lot of sense.”

Fran: “Yes? How does that kind of fit when you’re feeling like this?”

Tracey: “Um, very well, I know that I have like a problem with thinking the worst of every case scenario.”

Fran: “So that’s something you’ve already worked out.”

Framing the problem in terms of the modality was less explicit in CfD but was no less apparent in the choice of what was attended to by the therapist and the subtle reframing of a client’s problems. In the following two extracts, Don asked Rachel to frame her difficulties in terms of her emotional experiences. The first extract starts as Rachel began to understand what Don was asking for and explains why she found this difficult:

Rachel: “Perhaps I feel I don’t want to be judged any more than I already am? I don’t know, that’s not really a feeling, I don’t think I’m good at describing feelings, but I can tell you my thoughts about it.”

As the session progressed, Don increasingly interjected to steer Rachel towards naming her feelings, as in the following example where Rachel talked about an altercation at a bus stop during which her sexual orientation became the object of verbal abuse by a stranger:

Don: “Can I stop you there, Rachel. So what’s your feeling when, at that point, when?”

Rachel: “Oh, I didn’t like him after that, I was just like, ‘oh, you knob head.’”

Don: “So, what? Anger.”

Rachel: “Yes, why should he be able to say crap and – yes, so I was angry with him and upset about what he’d said.”

Rachel learns to work within the modality and, in line with CfD, the focus within the sessions continued on emotional processing.

**1.4 Accepting limitations.** Choosing a focus could also mean that aspects of a client’s needs, which they had brought to a session, were not addressed. In order to remain engaged, clients needed to achieve a workable trade-off between those needs which could be met in a session and those which remained unmet. This applied to both to therapies and problem choice. For example, Iris, in her second therapy session, expressed a pressing need to talk about an additional area of immediate distress in a style of working which was congruent with her previous experience of counselling, but conflicted with the more boundaried style of engagement agreed upon with her current CBT therapist. Iris has just finished describing a very difficult week:

Iris: “Everything has just been a mess this week. Really terrible.”

Lyn: “Ok, because your feedback last time, you recognised that when you used to come and see other counsellors, sometimes it’s just like ‘get it all off your chest’ which was good, but maybe didn’t move you forward. So we’ve kind of, we’re

going to have to get used to the new way of thinking, where like we're being quite structured, but we can't ignore what's gone on for you, it's how we work it."

For some, achieving a workable trade-off did not appear to happen in the first two sessions, as in the case of Jamie. When asked by Leslie what his main problem was, Jamie responded:

Jamie: "You make it sound like there's one specific problem."

Leslie: "OK yeah, there might be more than one. That is quite often the case. It's fine if there's more than one problem, just tell me what's wrong with your life basically."

Jamie: "I dunno, where do you want me to start?"

Jamie disclosed childhood sexual abuse and many other difficulties, but no agreed upon focus emerged from the session. Toward the end of the session, Leslie asked if the session had been difficult and Jamie agreed:

Leslie: "OK, ermm, I mean, I'm sensing this appointment is quite difficult for you, you're obviously doing your best to share stuff but I'm sensing it's quite difficult."

Jamie: "Yeah it is."

For some, accepting limits involved achieving a balance between hoped for change and realistic expectations, as illustrated in the following exchange between Roy and Sybill at the end of their first session:

Roy: "Well, I do feel better now – just talking through."

Sybill: "Thank you."

Roy: "I – really what I'd like to be saying is after – it's all done!"

Sybill: "That would be wonderful but sadly..."

Roy: (interrupts) "but you're not – are you? Ha."

Sybill: “That um, imaginary box that everything goes in doesn’t actually come with a magic wand, I’m afraid, ha, so.”

Roy: “I know, but I do feel better and at least I’m kind of smiling about things, so thank you, thank you.”

There was some evidence that clients also retrospectively evaluated therapy and identified where their needs had been unmet, as in the case of Roy who told Sybill about his past experience of CBT:

“See, when I did the CBT, which was ok, looking at the situation and how do you feel, you know and, but it doesn’t actually address, really address the core issues”.

## **2.0 Adapting to the Therapist**

**2.1 Developing and maintaining a relationship.** There was also evidence that, in order to engage, clients actively adapted to the developing relationship with their therapist. For some, this was aided by finding a natural complement in the interpersonal style of their therapist, as in the case of Iris, who expressed her appreciation by comparing Lyn to her previous therapists:

“I was thinking that I didn’t get anything, they were too soft with me really. I think that you maybe told me the truth and that, I think, the impression I’m getting from you, I don’t think you’d take any crap. You told me how it is, ‘look, you’re not doing this right, blah, blah, blah’. I mean, I get the impression that you mean business, whereas when I came to the other two, by the end of the session I could have fell asleep.”

For others, more exploration of the expectations that guided different ways of interpersonal relating in therapy was needed, as in the example of Darren and his therapist, Penny:

Darren: “I think in some ways I was trying to prepare myself so I could come here and not just sit here and I could, you know, try and be a little constructive in how I conduct myself.”

Penny: “So what would it be like to just come and, and show me how bad you can feel?”

Darren: “It wouldn’t be very helpful from your point of view, trying to get to the bottom of issues, would it?”

Penny: “I’d see, I’d see how bad it is. But, we’ll see what happens.”

Clients also used a range of normal conversational devices to build and maintain a rapport, including humour and positive feedback. In the following example Becky exchanged banter with Peter as she became more relaxed and comfortable in the relationship:

Peter: “But when you’re watching that, that has a positive effect on your mood?”

Becky: “It does if we win!”

Giving positive feedback to the therapist extended the process of rapport building further and was common to some degree across all transcripts. In many cases, this was given at the end of sessions in response to therapist enquiry, as in the example of Tracey and Fran:

Fran: “How have you found today’s session?”

Tracey: “Helpful, really helpful.”

Fran: “Yes, anything in particular that you’re taking away?”

Tracey: “Um, the map. It’s going to be – it’s left quite an impression.”

In some cases, feedback was also given spontaneously, mid-session, and served to support the direction taken by the therapist, as in the example of Becky and Peter:

Becky: “Um, I feel fine about giving it a go. Anything to try and help basically.”



Peter: “Yeah, yeah, ok I mean I suppose as the whole thing says, it can be quite hard work but...”

Becky: “But unless I take that step I’ll never know.”

**2.2 Investing in the therapist.** Clients demonstrated increased investment in their therapist through a variety of ways. In the following example, Rob increased the specificity of his feedback and tells his therapist what has helped, implicitly guiding Penny to what he found most helpful:

Penny: “Can I ask, how’s it felt?”

Rob: “I’ve found it really useful to be honest, it’s, I thought as soon as I mentioned there’s a trigger, 30 odd years back, that you’d say ‘no, let’s just go back to the last two weeks’ or something, and you haven’t, you’ve kind of honed in on that and that’s been useful, because you’re not discounting or saying ‘well, don’t be silly, you can’t be fretting about something that happened 30 years ago’ and to be honest, that’s what I think it really is.”

In the following example, Roy indicated how he has been reflecting on his therapist between sessions as well as describing what he has found beneficial:

“I was thinking very carefully about what we’d been through and almost like saying it was cathartic in a way, just – without anybody responding with any suggestions, because I know you just listened – anyway, so that made me feel better, that’s why I think I’ve felt better over the last week or so.”

Clients also signalled engagement when they accorded the relationship with the therapist a special or uniquely valued status. In the following comments, Rob indicated that Penny was positioned as someone to whom disclosures could be made safely and in confidence:

“I don’t know, I shouldn’t have done that. But of course, I can’t, it’s not something I can talk to my wife about really, is it?”

Likewise, Darren described his ability to be vulnerable with Penny and to speak about matters never before disclosed:

Penny: “How, how’s it feeling?”

Darren: “The things I’m saying I’ve never said ... So for the first time in ever I talked to someone else who don’t know me, I don’t know you (sniff), I’ve gotta be honest with you, I never thought I’d be, ever be this vulnerable, ever. I just weren’t a vulnerable chap, I suppose I’m the original English stiff upper lip geezer.”

Some clients explicitly named their disclosures as a secret, as in the case of Roy:

“Um, I find myself telling you secrets, do you know, things that I don’t ever tell anybody. The fact that I’m given things – you know like this, it’s given me an incentive to improve, to improve the way I’m living at the moment. It’s given me a little bit of hope.”

The extent to which Roy had invested in his therapist is further emphasised when he described his temporary state of dependence:

Roy: “I’m sinking, I’m thrashing around looking for something to hold on to, a piece of wood, just something, something to hang on to, that’s the only way I can describe it.”

Sybil: “And yet you ...”

Roy: (interrupts) “Unfortunately you’re it at the moment.”

**2.3 Working with the therapist’s lead.** In order to engage, clients followed their therapists’ lead at various points. This appeared to operate on a dynamic continuum with more reciprocal co-creating as the client became more familiar with the processes involved.

**2.3.1 Following the therapist.** Iris's previous expression of appreciation of her therapist's directive style is put to the test when she is asked to work on emotions, which she believes are, "a waste of time". In the following extract, Iris chose to follow her therapist's lead and complete the task:

Lyn: "Ok, I'm just going to be a little bit persistent with you, because when I asked you about your emotions, we know that you hide emotions; I think you started to do it there, you like kept talking. So just to go – to take you to an uncomfortable place, because you're used to avoiding it, when you tell yourself you're a failure, what does that do to your emotion?"

Iris: "It makes me feel sad, yes, it makes me feel really sad."

The theme developed over the session and later Iris allowed herself to cry and described the subsequent shame she experienced:

Lyn: "What will you tell yourself after today because you have cried? Or what are you telling yourself now?"

Iris: "Pathetic. Ridiculous, there's no reason to. Sorry."

**2.3.2 Struggling but trying.** In some cases, clients were motivated to follow their therapists' lead, but struggled to understand what was required. In the following exchange, Tracey struggled with developing a problem statement based on specific and concrete examples, but she remained fully engaged with Fran as she searched her experiences to give an answer:

Tracey: "Yes. Um, problem list. I think, um, I'm quite a big problem."

Fran: "Can you say a bit more about what you mean by that?"

Tracy: "Um, like, with my own self, I don't help myself, make myself feel quite rubbish."

Fran: “Mmm, ok, say a bit more about ...”

Tracy: “That’s my alarm. Oops. Um, I just – I feel – I make myself feel bad about myself.”

Fran: “So is that that kind of beating yourself up? Shall we put that down? That you beat yourself up?”

Tracy: “Yes, I think that’s quite a big problem.”

**2.2.3 Co-constructing.** As the client attuned to the therapist’s style and increasingly understood what was being asked for, engagement was often marked by increased reciprocity in exchanges with the therapist as they co-created an understanding. In the following example, Iris and Lyn discussed Iris’s need to help others and with each exchange, a more nuanced understanding was achieved:

Iris: “Disappointment, yes, or people aren’t going to confide in me or come to me with their problems because I can’t help or fix them.”

Lyn: “Yes. And you kind of said, ‘I’m worthless’?”

Iris: “Yes, in a sense, yes.”

Lyn: “Does that fit, or does that not quite fit right?”

Iris: “It, it does – I don’t feel worthless, it’s more a disappointment and just a general disbelief that I can’t – I don’t help. It’s a struggle – a really big struggle.”

Lyn: “So if you can’t help, then that’s really, really hard for you?”

Iris: “Yes, it’s, in a sense.”

### **3.0 Exercising Agency**

Asserting agency in their relationship with the therapist, learning about therapy, and choosing what to take from and how to use the interventions was applied flexibly by participants in response to other therapeutic processes.

**3.1 Setting boundaries and directing a focus.** Clients had a choice over what they revealed to therapists. In some cases, participants clearly asserted what they wished to focus or not focus on, as in the case of Becky. Becky disclosed sexual abuse when she was 12 years old, but said she did not want a therapy which focused on her past trauma:

Peter: “Right, ok, so it all sounds pretty horrendous. So in terms of how it’s affected you, have you had any sort of counselling or therapy to help you deal with that?”

Becky: “No.”

Peter: “And is that something that you’re interested in?”

Becky: “Not really because it means dragging up the past.”

Peter chose to accept Becky’s preference and did not challenge her in this session.

Arguably, Becky’s ability to communicate her preferences enabled her to stay engaged with her therapist and work on areas she felt ready to engage with. In other instances, clients directed the therapist towards their own understanding of their difficulties, as in the case of Rob:

Rob: “So it’s, um, I think my mental problem is I keep dwelling on happiness from the past and can’t really sort of counter that by current happiness. Sorry if I’ve gone on a bit there.”

The capacity to assert a focus, even when qualified by an apology, can be contrasted by Tracey, who struggled to assert her need for time in her therapy session to discuss a distressing experience, which occurred between sessions one and two. She had previously agreed an agenda with Fran where the matter could be talked about, but Fran ignored this and asked her to goal set. Tracey did not directly challenge Fran, but became increasingly limited in her responses and finally temporarily withdrew from the task and described herself as ‘going blank’:

Fran: “Was there any other goal that you were thinking you would like – if you were feeling happier, having fewer negative thoughts?”

Tracey: “Um, ... it’s stuck in my head now.”

Fran: “Yes, that’s ok. It might be something that we come back to?”

Tracey: “Um, umhum.”

Tracey began to talk with animation when Fran then suggested they change activities and talk about the issue Tracey had come to therapy with.

**3.2 Managing therapist contributions.** Asserting a lead could take place covertly through a process of selectively responding to or discounting therapist contributions, as well as expressing direct disagreement. While these processes may also be understood to represent defensive responses, within the present context they enabled the client to manage moments of difficulty with the therapist and remain engaged.

**3.2.1 *Selectively responding and discounting.*** In this example from her first session, Iris ignored her therapist’s attempt to change topic and in doing so she elicited a repeated reassurance that her difficulty with sleep would be attended to before she agreed to change topics:

Iris: “I mean, in the past, because I don’t sleep at all hardly, I haven’t slept for, oh, maybe - a couple of hours in the night and that’s about it.”

Lyn: “Ok, so we’ll come back to that as well, I reckon.”

Iris: “So they have tried to give me tablets to make me sleep, like, some sort of anti-depressant – I don’t – I won’t take tablets, for this problem.”

Lyn: Let’s come back to all of this.”

Iris: “That’s fine, absolutely fine.”

Selectively responding to the therapist and frequent interruptions were characteristic of the interaction between Darren and Penny. In the following fragment, Darren reflected

on his sense of incredulity at the number of traumatic events that had beset him. When he paused, Penny began to offer a reflection which he interrupted and appeared to ignore:

Darren: "It sounds a joke, don't it, really does, it sounds a bloody joke."

Penny: "It's as if you can't believe it, you couldn't believe that I could believe it all."

Darren (interrupts): "It's a joke, you can't make these things up - in the order that they went in and the aftermath, even after I left and stuff."

There may be more than one reason for the apparent lack of reciprocity in the exchanges between Darren and Penny, but his decision to interrupt or discount contributions by his therapist allowed Darren to continue to be engaged with his own train of thought or narrative flow. When Darren did respond to Penny, it appeared more often to occur when he was obviously distressed, as in the following example:

Darren: "I sat there for three days like stone, taking it all in ... I'm sorry (blow nose) oh dear sorry."

Penny: "And losing her left you lonely?"

Darren: "Oh God, I've never known anything like it, cos it took me through."

**3.2.2 Disagreeing.** For the most part, participants tended to avoid directly disagreeing with their therapist, but would sometimes do so, as in the following example where Rachel corrected Don's expressed understanding that she was ambivalent about therapy:

Don: "Yes, so you're saying is, actually for me, um, it was suggested by people I kind of respect, counselling might be helpful, but actually, it wasn't my own initiative really, and I'm kind of going along with."

Rachel: "And actually, I'm very open to counselling and I'm very open to um, I'm on medication but I don't think it works, but that's another story. But I'm very open to, um, sorting it out."

**3.3 Expressing relational needs.** Clients also gave therapists information about what they needed to maintain a relationship. Commonly, this would take the form of commenting favourably on some aspect of the therapist's style, but there were moments where clients would direct the therapist away from an area. In the following example, Darren provided a fairly confrontational challenge to Penny. Taken from Darren's perspective, this allowed him to remain engaged by providing Penny with information that enabled her to modify her reflection and avoid a possible rupture:

Darren (interrupts): "Is that a fault? Is it a fault? Don't tell me it's a fault, I won't know where to go."

Penny (laugh): "I certainly don't want to say it's a fault but it's, erm, I'm just noticing it, noticing."

In the following example, Roy confronted Sybill with his fear that she will be unable to cope with his need and disclosures, and in doing so sought confirmation of her continuing involvement:

Roy: "Well, it's whether you can, I don't know, almost whether you can stand it! Whether you can make sense of it! Or whether you feel you can help?"

Sybill: "I'd like to – I'd like to have the opportunity to try. It's – that's not my agenda, it's how you would feel. Having the opportunity."

Roy: "Um, I feel as if when I walk out of here I will feel better – will feel better – although, like some of the revelations."

Sybill: "But those revelations are the – as I said at the beginning – stay as -

Roy: "I understand that but I – I, um, in this – I care what you think. I care what you think."

**3.4 Loss of agency.** Where clients were unable to effectively assert their needs, engagement could become compliance. This was most apparent in the case of Jamie who



struggled with a behavioural activation approach. Jamie had failed to complete the homework diary and, after discussion of the reasons why he found it difficult, Leslie set the task again. At the end of the session, Jamie was asked for feedback and said the following:

Jamie: “Erm I feel anxious, feel a bit sick actually.”

Leslie: “Right so that suggests you feel very anxious, Yeah? Erm is there anything we can, any way I can help with that?”

Jamie: “Don’t make me do this, that’s about it.”

Leslie: “Right. Unfortunately I can’t do that”

Jamie: “Yeah, yeah, yeah.”

Leslie: “It is that, that is the key tool for getting people out of depression but as I say we could do three days rather than seven and, you know, as long as we’ve got three days we’ll have enough to talk about so would that be better if we do it every other day instead of every day?”

Jamie: “I’ll try and do it every day.”

Leslie: “Right OK. I’ll try and do it every hour (cough).”

Jamie oscillated between the extremes of “don’t ask me to do it” to “I’ll do it every hour” and he was unable to engage in continuing dialogue with his therapist as she suggested adaptations to the task. Although agreeing, his tone conveyed unhappiness.

### **Comparison of themes between CBT and CfD**

The analysis aimed primarily to examine themes common across CBT and CfD. Once this analysis was complete, a comparison of themes between CBT and CfD and between sessions one with sessions two was undertaken. This yielded no substantial differences in the underlying themes, however, the following points were observed. Firstly, the most obvious difference between CBT and CfD lay in more explicit learning to support CBT activities, while learning was often more implicit within CfD. Secondly, that

engagement was generally supported by explicit learning through therapist explanation and the opportunity for the client to check and revise their understanding.

With regard to comparisons between session one and two, session one included the majority of ‘orientation’ related themes and participants were typically more deferential to the therapist at the start of therapy with less evidence of agency. The prevalence of themes also varied between dyad. In part, this may have related to whether clients had a previous experience of therapy, a natural affinity with the treatment type, or a natural affinity with the style of their therapist, each of which appeared to support early engagement.

### **Discussion**

This study considered processes of early engagement in two psychotherapies for depression from the clients’ perspective. The findings suggested that, in order to engage, clients learn about and adapt to both the therapy and therapist, while also flexibly exercising agency to have their needs successfully met. Engagement also involves accepting the limits of what could be addressed by a particular intervention and the capacity to tolerate some degree of therapeutic misattunement.

These processes were represented by three higher order themes: ‘learning and adapting to the therapy’, ‘adapting to the therapist’, and ‘exercising agency’. ‘Learning and adapting to the therapy’ involved an initial period of ‘orientation’, during which clients received information about routine procedures and protocols. For some clients, the orientation period required that they contained and held the distress that had brought them to therapy, for example when confidentiality and risk was explained to a client experiencing suicidal thoughts. Engagement also required learning about generic therapeutic principles and those specific to treatment type. Some aspects of learning processes were explicit, such as completing homework diaries, but other learning was implicit, requiring that the client

assimilate a therapeutic culture. The ability to tolerate periods of confusion and uncertainty were inherent features of learning.

Clients also needed to choose a focus for therapy and frame their difficulties congruent with the treatment type. For some, there was a natural and fluid fit with existing understandings; for others this involved greater challenges. Framing and choosing a focus ultimately involved accepting the limitation of what could be achieved by a particular intervention. For some, a workable balance was struck, while for others this was never fully resolved.

In parallel to learning and adapting to the therapy, clients also learned about and adapted to their therapist. ‘Developing and maintaining’ a relationship with their therapist involved learning about the therapist’s interpersonal style and implicit expectations of the client. Clients actively attended to the relationship with their therapist through a process of rapport building. ‘Investing in the therapist’ was a necessary part of engagement, irrespective of the quality of the relationship, and could be signalled by according the therapist special and unique status within the client’s relational network, for example, as someone to whom secrets could be told. Clients also adapted to working with their therapist’s lead. This included following their therapists’ lead into new areas, for example, emotional expression, or the willingness to keep trying as they struggled to work out what was required. When able, clients also participated in co-constructing an understanding of their difficulties with their therapist through a process of reciprocal exchange. While this often was based on the lead initially presented by the therapist, clients would actively work to develop and apply the therapist’s suggestions to the way they understood their experience.

Learning and adapting to the modality and therapist necessarily involved the active exercise of agency by clients. Clients set boundaries on topics and influenced the focus of

discussion. Managing therapists' contributions was sometimes done through direct disagreement, but more often took place through discrete processes of what was attended to, or discounted in the micro-processes of conversational exchange. Similar processes were mobilized to help the client remain engaged despite disagreements.

Clients also communicated their relational needs; for example, seeking confirmation from the therapist that they continued to be held in positive regard, or warning the therapist when they felt relationally threatened. While it remains true that aspects of these processes could also be construed as defensive responses, when taken from the clients' perspective, they functioned to enable continuing engagement. Where clients were unable to flexibly exercise agency, difficulties arose and engagement became at best compliance, impacting on the tasks of therapy.

The presence of themes across both CBT and CfT provides partial support for Morris et al.'s (2014) argument that engagement consists of a pan-theoretical process, but this study only considered two therapies and therefore, these findings remain to be established across a range of modalities. Within the present study, there were some differences in the balance of themes between treatment type, with more evidence of explicit learning within CBT. In both modalities, session one typically focused on orientation activities; however, no other clear patterns emerged between treatment types and session number. Dyads varied in the prevalence of themes, with prior therapeutic experience of the treatment type increasing the ease of engagement. Where clients were unable to flexibly exercise agency, engagement became compliance. This was apparent in one transcript.

The initial engagement framework for this study started from the three dimensions of engagement proposed by Morris et al. (2014): cognitive, affective, and behavioural. While these may offer a useful method of categorizing markers of engagement from the therapists' perspective, the analyses found they were conceptually unhelpful in

characterising the underlying processes through which engagement developed from the clients' perspective. Of particular note in the present study was how engagement was actively constructed and maintained by the client through the exercise of agency in order to manage the process of learning and working with the therapist. The discussion now turns to examining the relationship between the main themes and wider literature.

Previous studies acknowledge that engagement necessarily involves the client's active participation in therapy (e. g. Hill, 2005; Holdsworth et al., 2014; Morris et al., 2014; Tetley et al., 2011) but have tended to model 'active engagement' as a response to conditions determined by the therapist, in which the client's role remains essentially a reactive rather than truly agentic one. For example, Tetley et al. (2011) defined engagement as the 'extent to which the client participates in the treatment on offer'. It follows from this understanding that markers of engagement will overlap with those of compliance, for example task completion, and attendance. Morris et al.'s (2014) understanding of engagement also remains grounded in an essentially reactive definition of client agency in which the client responds to the conditions set by the therapist. The present study suggests that engagement requires that clients flexibly exercise agency, at times following the therapist's lead, at others taking the lead to develop a relationship of mutual and reciprocal influence with the therapist and modality. This understanding of the client's role in therapy is congruent with a relatively small, but developing body of literature which led Bohart and Tallman (1999; 2010) to suggest that client activity should be understood as a further common factor in psychotherapy. Common factor refers to therapeutic processes thought to be present across all therapies irrespective of modality (Grencavage & Norcross, 1990).

In support of the active role of the client, Bohart and Tallman (2010) synthesized evidence from a range of sources. Of particular note is a series of qualitative studies using

the interpersonal recall method conducted by Rennie (1992, 1994, 2000, 2001, 2007).

Rennie (2007) found that while clients defer to the therapist, they also consciously take the lead to have their needs met. While acknowledging processes of transference and countertransference, Rennie (2007) concluded that clients make accurate assessments of their therapists which they integrate into their management of the therapy process. Consistent with the present study, Rennie (2000) argued that agency is exercised fluidly between client and therapist with differing levels of collaboration, acquiescence or assertion characterizing the relationship at any one moment.

Further support for client agency has emerged from more recent studies (e.g. Mackrill, 2008; Rolvsjord, 2015a; 2015b). Mackrill (2008), in a comparative study of diaries kept by therapists and clients, found that clients came to therapy with their own sense of what needed to change. In some instances, they adopted strategies suggested by the therapist; in other instances, they continued to privilege their own strategies disregarding, or adapting, those suggested by the therapist.

Rolvsjord (2015b), in an extension of Rennie's line of research using interpersonal recall method, similarly found that clients exercised agency in sessions at various points, while also deferring to the expertise of the therapist. Rolvsjord's (2015b) participants actively sought to develop mutuality, reciprocity and equality in their relationship with the therapist.

These studies and the results of the present analysis point, as commented, to the recognition of the active process of agency by the client, and show engagement to be a process developing out of a mutually determining relationship between therapist and client (Rolvsjord, 2015a; Raynor, Thompson, & Walsh, 2011).

However, in order to effectively exercise agency, clients also need to understand the principles and practices of therapy. The present study found that engagement requires that

clients learn at both an explicit and implicit level. There is a relatively slim literature on how clients learn to ‘do’ therapy. Orne and Wender (1968) first suggested that clients must grasp the “rules of the game”, which includes an understanding of therapy process, shared values and role expectancies. Learning was required across both CBT and CfD; however, it was apparent that the skills focus of CBT often carried the greater level of explicit learning in the study and was more often supported by direct education by the therapist which is consistent with guidance on socializing clients to this modality (Beck, Rush, Shaw, & Emery, 1979). In a preliminary study, Daniels and Wearden (2011) suggested that ‘socialization’ may be considered another non-specific factor in therapy which contributes to enhanced engagement. The learning required to participate in therapy is also acknowledged within other types of psychotherapy; for example, Peterson (2014) cited the need for a ‘trial period’ to improve outcomes for psychoanalytic therapy.

The literature on role induction provides further support for the need for learning to support psychotherapy. Role induction refers to provision of a discrete phase of learning prior to therapy. Overall, the effects of role induction appear to generally support better engagement (Walitzer, Dermen, & Connors, 1999) and it has been recommended to reduce therapeutic dropout (Swift & Greenberg, 2012). The results however are not unequivocal (Strassle, Borckardt, Handler, & Nash, 2011) and it may be that therapy at least in part needs to be learned in-vivo, with recognition of the distinction between explicit and implicit levels of learning accommodated for and supported.

Explicitly educating clients about therapy may also help clients to more clearly evaluate the acceptability of a treatment type and whether it is sympathetic to their existing understanding of their distress. The present study found that there appeared to be a more natural fit with existing ways of understanding for some clients, while for others learning was more burdensome as they struggled to make sense of a new way of thinking, which

for some conflicted with their existing values. Evidence from the field of client-treatment fit provides some support for the assertion that a poor fit between treatment type and client expectations and understanding negatively impinges on engagement and treatment outcome. Swift and Greenberg (2012) framed this as a cost-benefit understanding of premature termination, as clients actively make a decision about how useful a therapy is going to be in helping with their difficulties. Wilson and Sperlinger (2004) found that where clients often have a greater choice is within private therapy providers, and that they exercise this choice by ‘shopping around’ for the best fit. In a meta-analysis, Swift, Callahan, and Vollmer (2011) suggested that clients who had their preferences accommodated were less than half as likely to drop out of therapy as clients who had no such choices.

In an early study, which touched on the relationship between client conceptualizations of their difficulties and treatment outcome, Addis and Jacobson (1996) found that clients who held an existential understanding of the reason for their depression were likely to do better in cognitive rather than purely behavioural treatments. Similarly Elkin et al. (1999) found that engagement improved when patient’s own understanding of the reason for their difficulties and treatment preferences were accommodated. The results of the present study suggest that while clients work hard to make the best of what is offered, they may benefit from increased understanding of therapeutic processes and choice of therapy type.

### **Limitations and Research Implications**

A strength of this study is the focus on engagement from the client’s perspective and in doing so an under-researched area was targeted. However, engagement is essentially a reciprocal process and further research is needed to map the transactions which take place between therapist and client through which engagement is established. The choice of



method and number of transcripts limited the extent to which a fine-grained analysis was possible. While this allowed a broad characterization of the processes involved and met the aims of the present study, subsequent research could profitably focus on a more detailed analysis of individual transcripts at the conversational level, in order to understand how the micro process of conversational exchanges shape engagement processes.

The use of audio-recordings from therapy sessions resolved the inherent difficulty of qualitative enquiry wholly dependent on retrospective accounts, however, in doing so the researcher's interpretation of the processes was privileged. Future research may consider the use of interpersonal recall method to enable a better understanding of how participants interpret their behaviour.

Participants were recruited through a sample of convenience from those first entering the parent trial. This enabled randomisation, but it is unclear how representative the group were of participants commonly entering primary care. A number of variables not accounted for by this sampling method may have influenced engagement, including the age of participants, first or subsequent episode of depression, comorbidities, and prior therapeutic experience. Prior therapeutic experience may particularly have influenced learning processes and a non-randomised sampling technique would have enabled a choice to be made over whether to include clients with or without prior experience. The randomisation method also meant that transcripts which may have represented particularly rich examples of the engagement process were not prioritised over those where engagement was more limited. In this regard the sampling technique used may have limited exploration of engagement processes and the ability to gain insights and understandings.

The study benefited from examining two treatment types which are representative of the most commonly available treatments for depression in primary care; however, this limited the extent to which the process described can be considered pan-theoretical.

Further research is needed to establish whether these processes are representative across a wider range of modalities, client groups and mental health conditions, including more severe and enduring difficulties.

The choice to limit the analysis to the first two therapy sessions was justified in looking at early engagement processes; however, it was apparent that the pacing of the engagement process differed between dyads. Hill (2005) suggested that engagement changes and develops across the intervention and further research is needed to identify how this impacts on the processes described in these findings. The outcome of therapies was not known at the point of analysis, therefore no assumptions can be made about the long-term functionality of the processes described. It is possible that those therapies which maintain engagement in the short term do not necessarily result in the best outcomes. Research is needed into how engagement evolves over the span of a complete therapeutic intervention and what factors influence the speed at which engagement takes place.

Finally, in keeping with other modes of qualitative enquiry, template analysis is an interpretative process (King, 2004). The researcher recognizes their knowledge and experience of therapeutic process will have influenced the act of interpretation and other interpretations are possible.

### **Clinical Implications**

The present study found that to successfully engage, clients were active in developing and managing processes of learning and relationship building, as well as flexibly exercising agency in relationship with the therapist. Therapists should consider what clients already do to manage engagement and work with these strategies. This includes recognizing the preferences, strategies, and competences which clients bring to therapy and working in and through reciprocal processes to offer a more tailored

therapeutic response, actively working with client agency while promoting increased choice.

Recognition needs to be given to the power differential between the therapist and client, and an understanding of which practices can impede or support the exercise of agency by the client in the on-going dialogue between client and therapist. This may also include how the therapist manages their own response to client feedback based on an accurate appraisal of the relationship, while encouraging relational security and transparent disclosure.

The results suggest that clients will make the best of offered interventions, but some approaches may offer a better fit with the clients' existing understanding and needs, making the learning required to engage in therapy less burdensome. However, enhancing client choice and enabling the exercise of agency can only meaningfully take place when the choices are known and understood by clients. Enabling clients to become knowledgeable in therapeutic choices and equipping them with the skills to engage in therapy could be supported by pre-therapy information and increased therapist attention to these needs as they unfold across therapy.

Ultimately, offering clients increased choice and therapist flexibility may require more integrative working, which would require therapists to be equipped with the skills to exercise a clinical decision that balances consideration of the evidence base and fidelity to the model, with flexible adaptations to meet the needs of an individual. Consideration also needs to be given to offering choice over which therapist clients work with, in order to offer the best relational match.

## **Conclusion**

The present study examined engagement from the client's perspective and offers a starting point for further enquiry in an area which is under-theorized but integral to improving therapeutic outcomes. The study found that, in order to engage, clients adapt and learn about both the modality and therapist, while also flexibly exercising agency in order to have their needs met. In emphasizing the active role of the client in the therapeutic processes, this study makes a further contribution to a small but growing body of research which recognizes the client as a common factor in therapy and the determining effect of client agency on therapeutic processes. Further research is needed to test the applicability of the findings across other client groups and areas of psychological difficulty, and to map how processes of client engagement interact with therapist factors.

## References

- Addis, M. E., & Jacobson, N. S. (1996). Reasons for depression and the process and outcome of cognitive-behavioral psychotherapies. *Journal of Consulting and Clinical Psychology, 64*, 1417-1424. doi:10.1037/0022-006X.64.6.1417
- Bados, A., Balaguer, G., & Saldaña, C. (2007). The efficacy of cognitive-behavioral therapy and the problem of dropout. *Journal of Clinical Psychology, 63*, 585-592. doi:10.1002/jclp.20368
- Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: a critical review. *Psychological Bulletin, 82*, 738-783. doi:10.1037/h0077132
- Barkham, M., Connell, J., Stiles, W. B., Miles, J. N., Margison, F., Evans, C., & Mellor-Clark, J. (2006). Dose-effect relations and responsive regulation of treatment duration: the good enough level. *Journal of Consulting and Clinical Psychology, 74*, 160-167. doi:10.1037/0022-006X.74.1.160
- Barrett, M. S., Chua, W. J., Crits-Christoph, P., Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, & Training, 45*, 247-267. doi: 10.1037/0033-3204.45.2.247
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: Guilford Press.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for Beck depression inventory-II*. San Antonio, TX: Psychological Corporation.
- Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck depression inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*, 77-100. doi:10.1016/0272-7358(88)90050-5

- Bohart, A. C., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.
- Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor. In B. L. Duncan, S. D. Miller, B. Wampold, & M. Hubble (Eds.), *The heart and soul of change*. (pp 83–112). Washington, DC: American Psychological Association.
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16, 252-260.  
doi:10.1037/h0085885
- Brandt, L. W. (1965). Studies of "Dropout" patients in psychotherapy: A review of findings. *Psychotherapy: Theory, Research & Practice*, 16, 252-267.  
doi:10.1037/h0088610
- Brooks, J., & King, N. (2012). Qualitative psychology in the real world: the utility of template analysis. In *British Psychological Society Annual Conference*, London, UK. Retrieved from <http://eprints.hud.ac.uk/13656/>
- Brooks, J., McCluskey, S., Turley, E., & King, N. (2015). The utility of template analysis in qualitative psychology research. *Qualitative Research in Psychology*, 12, 202-212. doi:10.1080/14780887.2014.9552
- Cooper, A. A., & Conklin, L. R. (2015). Dropout from individual psychotherapy for major depression: A meta-analysis of randomized clinical trials. *Clinical Psychology Review*, 40, 57-65. doi:10.1016/j.cpr.2015.05.001
- Cuijpers, P., van Straten, A., Warmerdam, L., & Anderson, G. (2008). Psychological treatment of depression: A meta-analytic database of randomized studies. *BMC Psychiatry*, 8, 36-41. doi:10.1186/1471-244X-8-36

- Daniels, J., & Wearden, A. J. (2011). Socialization to the model: The active component in the therapeutic alliance? A preliminary study. *Behavioural and Cognitive Psychotherapy*, 39, 221-227. doi:10.1017/S1352465810000792
- Elkin, I., Yamaguchi, J., Arnkoff, D., Glass, C., Sotsky, S., & Krupnick, J. (1999). "Patient-treatment fit" and early engagement in therapy. *Psychotherapy Research*, 9, 437-451. doi:10.1080/10503309912331332851
- Evans, C., Connell, J., Barkham, M., Margison, F., Mellor-Clark, J., McGrath, G., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. *British Journal of Psychiatry*, 180, 51-60. doi:10.1192/bjp.180.1.51
- Glaser, B. G., & Strauss, A. L. (2009). *The discovery of grounded theory: Strategies for qualitative research*. London, UK: Transaction Publishers.
- Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice*, 21, 372-378 doi:10.1037/0735-7028.21.5.372.
- Haynes, K. (2012). Reflexivity in Qualitative Research. In G. Symon, & C. Cassell, (Eds.) *Qualitative Organisational Research*. (pp. 72-89) London, UK: Sage Publications Ltd.
- Hiler, E. (1958). An analysis of patient therapist compatibility. *Journal of Consulting Psychology*, 22, 341-347. doi:10.1037/h0045173
- Hill, A. (2011). Curriculum for counselling for depression: Continuing professional development for qualified therapists delivering high intensity interventions. National IAPT Programme Team. Retrieved from <http://www.iapt.nhs.uk/silo/files/curriculum-for-counselling-for-depression.pdf>
- Hill, C. (2005). Therapist techniques, client involvement and the therapeutic relationship:

Inextricably intertwined in the therapy process. *Psychotherapy: Theory, Research, Practice, Training*, 42, 431-442. doi:10.1037/0033-3204.42.4.431

Holdsworth, E., Bowen, E., Brown, S., & Howat, D. (2014). Client engagement in psychotherapeutic treatment and associations with client characteristics, therapist characteristics, and treatment factors. *Clinical Psychology Review*, 34, 428-450. doi:10.1016/j.cpr.2014.06.004

King, N. (2004). Using templates in the thematic analysis of texts. In G. Symon, & C. Cassell, (Eds.) *Essential guide to qualitative methods in organizational research*. (pp.256-270). London, UK: Sage Publications Ltd.

King, N. (2012). Doing Template Analysis. In G. Symon, & C. Cassell, (Eds.) *Qualitative Organisational Research*. (pp. 426-250) London, UK: Sage Publications Ltd.

Lueger, R. J., Howard, K. I., Martinovich, Z., Lutz, W., Anderson, E. E., & Grissom, G. (2001). Assessing treatment progress of individual patients using expected treatment response models. *Journal of Consulting and Clinical Psychology*, 69, 150-158. doi:10.1037/0022-006X.69.2.150

Mackrill, T. (2008). Exploring psychotherapy clients' independent strategies for change while in therapy. *British Journal of Guidance and Counselling*, 36, 441- 453. doi:10.1080/03069880802343837

McCluskey, S., Brooks, J., King, N., & Burton, K. (2011). The influence of significant others' on persistent back pain and work participation: A qualitative exploration of illness perceptions. *BMC Musculoskeletal Disorders*, 12. doi:10.1186/1471-2474-12-236

Morris, E., Fitzpatrick, M. R., & Renaud, J. (2014). A pan-theoretical conceptualization of client involvement in psychotherapy. *Psychotherapy Research*, Advanced online publication. doi:10.1080/10503307.2014.935521



- NICE (2009). *Depression: Treatment and management of depression in adults*. Clinical Guideline 90. London, UK: National Institute for Health and Clinical Excellence.  
Retrieved from: <https://www.nice.org.uk/guidance/cg90>
- Orne, M., & Wender, P. (1968). Anticipatory socialization for psychotherapy: Method and rationale. *American Journal of Psychiatry*, 124, 1202-1212.  
doi:10.1176/ajp.124.9.1202
- Owen, J., Adelson, J., Budge, S., Wampold, B., Kopta, M., Minami, T., & Miller, S. (2015). Trajectories of change in psychotherapy. *Journal of Clinical Psychology*, 71, 817-827. doi:10.1002/jclp.22191
- Peterson, C. A. (2014). The trial period and the creation of analytic patients. *International Forum of Psychoanalysis*, 23, 209-219. doi:10.1080/0803706X.2012.661875
- Rayner, K., Thompson, A. R., & Walsh, S. (2011). Clients' experience of the process of change in cognitive analytic therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 299-313. doi:10.1348/147608310X531164
- Rennie D.L. (1992). Qualitative analysis of the client's experience of psychotherapy, the unfolding of reflexivity. In S.G. Toukmanian and D.L. Rennie (Eds.), *Psychotherapy process research: paradigmatic and narrative approaches*. (pp211-233). London, UK: Sage Publications Ltd.
- Rennie, D.L. (1994). Clients' deference in psychotherapy. *Journal of Counselling Psychology*, 41, 427-37. doi:10.1037/0022-0167.41.4.427
- Rennie, D.L. (2000). Aspects of the client's control of the psychotherapeutic process. *Journal of Psychology Integration*, 10, 151-167. doi:10.1023/A:1009496116174
- Rennie, D.L. (2001). The client as a self-aware agent in counselling and psychotherapy. *Counselling and Psychotherapy Research*, 1, 82-89.  
doi:10.1080/14733140112331385118

- Rennie, D. L. (2007). Reflexivity and its radical form: Implications for the practice of humanistic psychotherapies. *Journal of Contemporary Psychotherapy*, 37, 53-58. doi:10.1007/s10879-006-9035-8
- Rogers, C. R. (1951) *Client-centered therapy: Its current practice, implications and theory*. Boston, MA: Houghton Mifflin.
- Rolvstjor, R. (2015a). What clients do to make music therapy work: A qualitative multiple case study in adult mental health care. *Nordic Journal of Music Therapy*, 24, 296-321. doi:10.1080/08098131.2014.964753
- Rolvstjor, R. (2015b). Five episodes of clients' contributions to the therapeutic relationship: a qualitative study in adult mental health care. *Nordic Journal of Music Therapy*. Online publication ahead of print. doi:10.1080/08098131.2015.1010562
- Sayer, A. (2000). *Realism and social science*. London, UK: Sage Publications Ltd.
- Simon, G. E., Ding, V., Hubbard, R., Fishman, P., Ludman, E., Morales, L., Operskalsk, B., & Savarino, J. (2012). Early dropout from psychotherapy for depression with group-and network-model therapists. *Administration and Policy in Mental Health and Mental Health Services Research*, 39, 440-447. doi:10.1007/s10488-011-0364-x
- Skärsäter, I., Dencker, K., Bergbom, I., Häggström, L., & Fridlund, B. (2003). Women's conceptions of coping with major depression in daily life: a qualitative, salutogenic approach. *Issues in Mental Health Nursing*, 24, 419-439. doi:10.1080/01612840305313
- Smith, J.A., Flowers, P., & Larkin, M. (2009) *Interpretative phenomenological analysis: Theory, method and research*. London, UK: Sage Publications Ltd.

- Steinert, C., Hofmann, M., Kruse, J., & Leichsenring, F. (2014). Relapse rates after psychotherapy for depression—stable long-term effects? A meta-analysis. *Journal of Affective Disorders*, 168, 107-118. doi:10.1016/j.jad.2014.06.043
- Stiles, W. B., Barkham, M., & Wheeler, S. (2015). Effect of duration of psychological therapy on recovery and improvement rates: Evidence from UK routine practice. *The British Journal of Psychiatry*, 1, 115-122. doi:10.1192/bjp.bp.114.145565
- Stiles, W.B., Leach, C., Barkham, M. Lucock, M., Iveson, S., Shapiro, D.A., Iveson, M., & Hardy, G.E. (2003). Early sudden gains in psychotherapy under routine clinic conditions: Practice-based evidence. *Journal of Consulting and Clinical Psychology*, 71, 14-21. doi:10.1037/0022-006X.71.1.14
- Strassle, C. G., Borckardt, J. J., Handler, L., & Nash, M. (2011). Video-tape role induction for psychotherapy: Moving forward. *Psychotherapy*, 48, 170-178. doi: 10.1037/a0022702
- Strauss, A. & Corbin, J. (1994). Grounded theory methodology. In N. K. Denzin and Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273-285). Thousand Oaks, California: Sage Publications Ltd.
- Swift, J. K., Callahan, J. L., & Vollmer, B. M. (2011). Preferences. *Journal of Clinical Psychology*, 67, 155-165. doi:10.1002/jclp.20759
- Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 80, 547-559. doi:10.1037/a0028226
- Swift, J. K., & Greenberg, R. P. (2014). A treatment by disorder meta-analysis of dropout from psychotherapy. *Journal of Psychotherapy Integration*, 24, 193. doi:10.1037/a0037512

- Tetley, A., Jinks, M., Huband, N., & Howells, K. (2011). A systematic review of measures of therapeutic engagement in psychosocial and psychological treatment. *Journal of Clinical Psychology*, 67, 927-941. doi:10.1002/jclp.20811
- Walitzer, K. S., Dermen, K. H., & Connors, G. J. (1999). Strategies for preparing clients for treatment: A review. *Behavior Modification*, 23, 129-151.  
doi:10.1177/0145445599231006
- Wampold, B. E. (2011). *Qualities and actions of effective therapists*. Retrieved from <http://www.apa.org/education/ce/effective-therapists.pdf>
- Wilson, M., & Sperlinger, D. (2004). Dropping out or dropping in? A re-examination of the concept of dropouts using qualitative methodology. *Psychoanalytic Psychotherapy*, 18, 220-237. doi:10.1080/14749730410001700705

## Appendix D

Top Level Theme	Sub-Theme	Notes	Evidence
<i>Learning and adapting to the modality</i>	Orientation	Information at start of session – it's fairly extensive, client gives assent	1.3. T: Um, now, before we get stuck into stuff, I've got like a little – things that I always go through with people so you know where you stand – if that makes – (alright)
		Does not question, even where there are some challenging assertions about what is expected of her. What learning will be required, how does this make her feel?	1.11. T: this is more intensive; (right) sort of greater expectations on you, um, greater expectations on me as well I guess. So I'll go into greater detail about what that entails, just to make sure you want to do this, basically. C:Ok
	Learning the ropes / choosing a focus	Terminology confuses her? - note “being told” and tone of voice when she says this. Quite challenging – does she think she is depressed?  Role of between session work in CBT. Lack of clarity over expectations - last week's transcripts therapist did not ask her to bring back. Note, client does not challenge here, apologies.	C: Yes. What's the difference between depression and CBT? Because I'd never been told I'd got depression.  T: Ok, so just before we go on to that, in terms of homework, because as you know, homework is like a critical part of CBT - C: I did read them both. T: And have you brought them back with you? C: Oh, did I need to? (Yes) Oh, I thought they were mine to keep, sorry!

C: Oh, yes, but as long as I understand the ropes?

Top Level Theme	Sub-Theme	Notes	Evidence
	Learning the ropes	Indicates that she had previously gone through a complete episode of therapy without understanding when she completed the measures! Notice she did this / I “assume” did not communicate her lack of understanding at the time– how can therapist know if actively is meaningful – engagement is about more than task completion.	C: Oh, yes, but as long as I understand, like you’ve told me about these results and the scales and everything (yes). If I understand what’s happening, then I’m happy with it. But nobody explained anything before. I was just like – it just went over my head, because I didn’t understand what it was about, because nobody ever told me.
	Framing the problem	Very early stages of finding a focus - at the moment she does not have an understanding how CBT formulates problems. Difficulty finding a focus is first expressed when she is asked to ‘choose’ using a diagnostic category. Wider transcripts suggests she thinks of her problems more in terms of her relationships.	C: Um, the social phobia thing, ticked a lot of boxes. (ok) And I read it several times and I thought, yes, I would think that is – that is more related to me than the depressions bit. (really, ok) But then I thought, when I read the depression bit, I thought the way I felt this week, that related to (hmm) more to me than the social phobia. (hmm) So I’m a bit confused now, as to what’s what. (What’s what) Because I never recognised that I had depression, because I could deal with anything. (yes, hmm) But I did realise that the social phobia thing was exactly what is happening. But this week, it’s swayed more towards the other paper.

Top Level Theme	Sub-Theme	Notes	Evidence
	Accepting limits	<p>Ways of working – she has previously expressed a preference for the structure and focus of CBT, but here struggles with the loss of a more ‘counselling’ orientated approach. Note also the content – her relational difficulties, especially marital simmer across two sessions but it’s not foregrounded as a focus for therapy.</p>	<p>C: my niece had her dog put down on Friday, my brother – my dad’s dog, who’s – I lost my dad as you know, but my step-brother’s got his dog, she collapsed, she – found out she got cancer, had major surgery, then collapsed on Sunday – he can’t do anything for himself, and everything has just been a mess this week. Really terrible. And my husband is so stupid, he’s – I mean, I only asked him to do a salad last night when I was at work, we boiled eggs and that for my daughter when she got in from work – he let the pan boil dry, nearly set the house on fire – the kitchen – he’s so irresponsible, I could scream. He’s just getting me down so much. (<i>C sighs deeply</i>)</p> <p>R: Ok, because your feedback last night, you recognised that when you used to come to see other counsellors, sometimes it’s just like ‘get it all off your chest’ (yes) which was good, but maybe didn’t move you forward, (hmm) So we’ve kind of, we’re going to have to get used to the new way of thinking, where like we’re being quite structured, but we can’t ignore what’s gone on for you, it’s how we work it.</p> <p>P1: No, I don’t mind anything, honestly.</p>

Note: ‘T’: Therapist; ‘C’: Client

<p>Client begins to demonstrate her developing understanding of the basic rational for CBT – this is offered spontaneously. Therapist nudges understanding</p>	<p>Client: like basically the way depression like kind of works, so like the way you think, it's like affects how you feel, also affects your behaviour. Therapist : Yeah, good, good, so we'll do that but it'll be specifically for you and your situation, yeah? Client: yeah</p>	<p>“Learning the ropes”</p>
<p>Here client chooses to follow the therapist at the start of the session, note - compare to later in session when she asserts a lead.</p>	<p>Therapist: Um, so was there anything you wanted to focus on today? Client: No not really Therapist: No? Ok, so do you wanna start with the questionnaire then? Client: yeah</p>	<p>What about agency? “Following the therapist lead”</p>
<p>At this juncture the client is bearing with an administrative exercise - no context has been yet set to make completing measures meaningful</p>	<p>Therapist: So although it says 2 weeks, just think about last week. (ok) because I only saw you a week ago. 2:58 - 5:54 is silence except for papers shuffle, a cough, a sniff etc]. Client: I've done Therapist: Ok, thank you, thanks for that – clears throat- so let's just have a quick look at this-</p>	



<p>Correcting an error</p> <p>Revises understanding as part of learning – increasing accuracy of understanding – notices that she explains this to the therapist.</p>	<p>Client: I've circled the wrong one on the back of it there, 'cause I read it wrong (oh, ok). So I've like scribbled it out and ?</p>	<p>Explicit learning about completing the measures</p> <p>Orientation</p>
<p>Seems to accept the therapist's view that she is progressing, but guides an understanding of how the reduction in her scores should be interpreted. In doing so she guides the therapist to a line of enquiry?</p>	<p>Therapist: [papers shuffle] Ok, (...) [papers shuffle] er, yeah, so thanks for that (that's ok) and your scores have come down (ahum) which is good, heading in the right direction.</p> <p>Client: It's because at the moment I'm just working <del>so much</del> (ok) I just don't have time to concentrate on anything else (ok) so (right). Work's keeping me busy.</p> <p>Therapist: Yeah, and how's work going?</p>	<p>She is beginning to frame consistent with the modality – drawing a link between activity levels and mood</p>

## Appendix E



### Health Research Authority

NRES Committee Yorkshire & The Humber - South Yorkshire

North East REC Centre  
Unit 002, TEDCO Business Centre  
Rolling Mill Road  
Jarrow  
Tyne and Wear  
NE32 3DT

Telephone: 0191 428 3561

27 March 2014

Professor Michael Barkham  
Director, Centre for Psychological Services Research  
University of Sheffield  
Dept of Psychology  
University of Sheffield  
Western Bank  
SHEFFIELD  
S10 2TN

Dear Professor Barkham

**Study title:** A pragmatic non-inferiority randomised controlled trial of the clinical and cost-effectiveness of counselling for depression versus cognitive-behaviour therapy, for clients in primary care meeting a diagnosis of moderate or severe depression: The PRACTICED Trial

**REC reference:** 14/YH/0001

**IRAS project ID:** 130352

Thank you for your letter of 25 March 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 04 February 2014

#### Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Interview Schedules/Topic Guides	Interview Topic Guide / Version 2.0	25 March 2014
Participant Consent Form: Main Consent Form	Version 2.0	25 March 2014

## Approved documents

The final list of approved documentation for the study is therefore as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter	Michael Barkham	11 December 2013
Evidence of insurance or indemnity	The University of Sheffield	13 November 2013
GP/Consultant Information Sheets	Information Sheet for GP, V1.0	20 November 2013
GP/Consultant Information Sheets	GP Notification, V1.0	20 November 2013
GP/Consultant Information Sheets	GP Risk Letter, V1.0	20 November 2013
Interview Schedules/Topic Guides	Brief Exit Interview, V1.0	20 November 2013
Interview Schedules/Topic Guides	Interview Topic Guide / Version 2.0	25 March 2014
Investigator CV	Michael Barkham	16 November 2013
Letter of invitation to participant	Patient Information from PWP, V1.0	20 November 2013
Other: CV - Student Research Supervisor	Gillian E. Hardy	16 November 2013
Other: Student CV	Caroline Dunsmuir-White	16 November 2013
Other: Student CV	Kim Campbell	16 November 2013
Other: Letter from Funder	BACP Research Foundation	19 November 2013
Other: Adverse Events Reporting - Study Specific Procedure	V1.0	20 November 2013
Other: Risk Protocol - Research Interviews	V1.0	20 November 2013
Other: Risk Form for Suicide and Self Harm	V1.0	20 November 2013
Other: Risk Form for Risks Not Including Suicide and Self Harm	V1.0	20 November 2013
Participant Consent Form: Consent to Contact	V1.0	20 November 2013
Participant Consent Form: Consent to Interview	V1.0	20 November 2013
Participant Consent Form: Main Consent Form	Version 2.0	25 March 2014
Participant Information Sheet: PIS Main Trial	V1.0	20 November 2013
Participant Information Sheet: Patient Information for Assessment	V1.0	20 November 2013
Protocol	V1.0	20 November 2013
Questionnaire: Treatment Preference		
Questionnaire: Therapy Expectation Form		
Questionnaire: CIS-R		
Questionnaire: BDI-II		
Questionnaire: PHQ-9		
Questionnaire: GAD-7		
Questionnaire: EQ-5D		
Questionnaire: Wellbeing-VAS		
Questionnaire: CORE-OM		
Questionnaire: Work and Social Adjustment Scale		
Questionnaire: CD-RISC		

A Research Ethics Committee established by the Health Research Authority

Questionnaire: MINI Diagnostic - Sections I&J		
Questionnaire: CSSRI-EU		
Questionnaire: Client Satisfaction		
REC application	IRAS V3.5	21 November 2013
Referees or other scientific critique report	Peer Review 1	
Referees or other scientific critique report	Peer Review 2	
Referees or other scientific critique report	Peer Review 3	
Summary/Synopsis	Flowchart Recruitment, V1.0	20 November 2013
Summary/Synopsis	Consort, Wave 1, V1.0	20 November 2013
Summary/Synopsis	Consort: Wave 2, V1.0	20 November 2013
Summary/Synopsis	SOP Recruitment	20 November 2013
Summary/Synopsis	SOP Patient Treatment, V1.0	20 November 2013

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

<b>14/YH/0001</b>	<b>Please quote this number on all correspondence</b>
-------------------	---

Yours sincerely



**Kerry Dunbar**  
**REC Assistant**

E-mail: [nrescommittee.yorkandhumber-southyorks@nhs.net](mailto:nrescommittee.yorkandhumber-southyorks@nhs.net)

Copy to: *Mr David Saxon, University of Sheffield*  
*Mr Nicolas Bell, Sheffield Health & Social Care NHS Foundation Trust*



## **Health Research Authority**

**NRES Committee Yorkshire & the Humber - South Yorkshire**

North East REC Centre  
Unit 002, TEDCO Business Centre  
Rolling Mill Road  
Jarrow  
Tyne and Wear  
NE32 3DT

Telephone: 0191 428 3566  
Facsimile: 0191 428 3432

04 February 2014

Professor Michael Barkham  
Director, Centre for Psychological Services Research  
Department of Psychology  
University of Sheffield  
Western Bank  
SHEFFIELD  
S10 2TN

Dear Professor Barkham

**Study title:** A pragmatic non-inferiority randomised controlled trial of the clinical and cost-effectiveness of counselling for depression versus cognitive-behaviour therapy, for clients in primary care meeting a diagnosis of moderate or severe depression: The PRaCTICED Trial

**REC reference:** 14/YH/0001

**IRAS project ID:** 130352

The Research Ethics Committee reviewed the above application at the meeting held on the 30 January 2014. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Mrs Joan Brown, [nrescommittee.yorkandhumber-southyorks@nhs.net](mailto:nrescommittee.yorkandhumber-southyorks@nhs.net).

### **Ethical opinion**

It was queried whether you were applying for approval of the whole RCT as well as what the students would be doing and you confirmed that ethical approval was being sought for the whole trial.

It was observed that the only issue with the application was that there was no indication of the topics that would be discussed with the people who dropped out of the study. It was explained that this was a work in progress and would be submitted to the REC once it had been finalised.

It was observed there was a minor clarification required in the consent form.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, **subject to the conditions specified below.**

#### **Ethical review of research sites**

##### **NHS Sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

#### **Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

- 1. Submit a revised Consent Form as follows: Amend Point 5 to read "I understand that data collected during the study may be looked at by individuals from the study team or individuals from regulatory authorities or the NHS Trust where it is relevant to my taking part in this study. I give permission for these individuals to have access to my records"**
- 2. Submit a copy of the interview schedule that will be used for people who drop out of the study once it has been finalised for information only. There is no need for the schedule to be approved by the REC.**

**You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.**

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

## Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett ([catherineblewett@nhs.net](mailto:catherineblewett@nhs.net)), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

**It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

## **Approved documents**

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter	Michael Barkham	11 December 2013
Evidence of insurance or indemnity	The University of Sheffield	13 November 2013
GP/Consultant Information Sheets	Information Sheet for GP, V1.0	20 November 2013
GP/Consultant Information Sheets	GP Notification, V1.0	20 November 2013
GP/Consultant Information Sheets	GP Risk Letter, V1.0	20 November 2013
Interview Schedules/Topic Guides	Interview Topic Guide, V1.0	20 November 2013
Interview Schedules/Topic Guides	Brief Exit Interview, V1.0	20 November 2013
Investigator CV	Michael Barkham	16 November 2013
Letter of invitation to participant	Patient Information from PWP, V1.0	20 November 2013
Other: CV - Student Research Supervisor	Gillian E. Hardy	16 November 2013
Other: Student CV	Caroline Dunsmuir-White	16 November 2013
Other: Student CV	Kim Campbell	16 November 2013
Other: Letter from Funder	BACP Research Foundation	19 November 2013
Other: Adverse Events Reporting - Study Specific Procedure	V1.0	20 November 2013
Other: Risk Protocol - Research Interviews	V1.0	20 November 2013
Other: Risk Form for Suicide and Self Harm	V1.0	20 November 2013
Other: Risk Form for Risks Not Including Suicide and Self Harm	V1.0	20 November 2013

Participant Consent Form: Main Consent Form	V1.0	20 November 2013
Participant Consent Form: Consent to Contact	V1.0	20 November 2013
Participant Consent Form: Consent to Interview	V1.0	20 November 2013
Participant Information Sheet: PIS Main Trial	V1.0	20 November 2013
Participant Information Sheet: Patient Information for Assessment	V1.0	20 November 2013
Protocol	V1.0	20 November 2013
Questionnaire: Treatment Preference		
Questionnaire: Therapy Expectation Form		
Questionnaire: CIS-R		
Questionnaire: BDI-II		
Questionnaire: PHQ-9		
Questionnaire: GAD-7		
Questionnaire: EQ-5D		
Questionnaire: Wellbeing-VAS		
Questionnaire: CORE-OM		
Questionnaire: Work and Social Adjustment Scale		
Questionnaire: CD-RISC		
Questionnaire: MINI Diagnostic - Sections I&J		
Questionnaire: CSSRI-EU		
Questionnaire: Client Satisfaction		
REC application	IRAS V3.5	21 November 2013
Referees or other scientific critique report	Peer Review 1	
Referees or other scientific critique report	Peer Review 2	
Referees or other scientific critique report	Peer Review 3	
Summary/Synopsis	Flowchart Recruitment, V1.0	20 November 2013
Summary/Synopsis	Consort, Wave 1, V1.0	20 November 2013
Summary/Synopsis	Consort: Wave 2, V1.0	20 November 2013
Summary/Synopsis	SOP Recruitment	20 November 2013
Summary/Synopsis	SOP Patient Treatment, V1.0	20 November 2013

### Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.



## After ethical review

### Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

**14/YH/0001**

**Please quote this number on all correspondence**

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



**pp Ms Jo Abbott  
Chair**

Email: [nrescommittee.london-camdenandislington@nhs.net](mailto:nrescommittee.london-camdenandislington@nhs.net)

*Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments  
“After ethical review – guidance for researchers” SL-AR-2*

*Copy to: Mr David Saxon, University of Sheffield*

*Mr Nicolas Bell, Sheffield Health & Social Care NHS Foundation Trust*

**NRES Committee Yorkshire & the Humber - South Yorkshire**

**Attendance at Committee meeting on 30 January 2014**

**Committee Members:**

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Ms Jo Abbott (Chair)	Consultant in Public Health	Yes	
Dr Ahmed H Abdelhafiz	Consultant Physician, Elderly Medicine	Yes	
Dr Peter Allmark	Principal Nursing Lecturer	No	
Reverend Joan Ashton	Co-ordinator of Chaplaincy Services	Yes	
Ms Helen Barlow	Knowledge Service Manager	Yes	
Professor Nigel Beail	Consultant Clinical Psychologist & Professor of Psychology	Yes	
Mr Ian Cawthorne	Chief Pharmacist	No	
Ms Susan Hampshaw	Head of Research, Evaluation and Innovation	Yes	
Mr Neil Marsden	Police Staff	Yes	
Dr Duane Mellor	Lecturer in Dietetics	No	
Mrs Andrea Porritt	Community Specialist Practitioner/District Nurse	Yes	
Mrs Carole Taylor	Deputy Chief Pharmacist	Yes	

**Also in attendance:**

<i>Name</i>	<i>Position (or reason for attending)</i>
Ms Joan Brown	REC Manager

## Appendix F

PRaCTICED Study: Main Consent Form v2.0 25.03.14



### PRaCTICED Study

#### Research participant consent form

If you are interested in taking part in the PRaCTICED study, please read through the points below and note any queries you may have. When you attend the assessment with a member of the research team, they will talk you through the points and answer any questions you may have about the study. Only then will you be asked to complete this form.

Please **INITIAL** box

- |    |   |                      |
|----|---|----------------------|
| 1  | I confirm that I have read and understand the information sheet dated 20.11.13 (version 1) for the above study. I have had the opportunity to consider the information, ask questions about the study and understand why this research is being done  | <input type="text"/> |
| 2  | I understand that I may not be eligible to take part in the study   | <input type="text"/> |
| 3  | I agree to complete the relevant questionnaires at 3, 6 and 12 months after entering the study  | <input type="text"/> |
| 4  | I agree to my GP being informed of my participation in the study and of any health concerns the study team may become aware of during my participation  | <input type="text"/> |
| 5  | I understand that data collected during the study – as with all data collected within routine NHS service delivery – may be looked at by individuals from the study team or individuals from regulatory authorities or the NHS Trust where it is relevant to my taking part in this study. I give permission for these individuals to have access to my records | <input type="text"/> |
| 6  | I understand that, as part of normal practice, my sessions will be audio-recorded for the purposes of supervision   | <input type="text"/> |
| 7  | I understand that some of these audio-recordings may be listened to by researchers either with the purpose of ensuring that the treatments are being delivered appropriately or to enable a better understanding of these treatments  | <input type="text"/> |
| 8  | I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected  | <input type="text"/> |
| 9  | I understand that I may be approached to take part in an additional interview as part of the study, and that I will be given further information and another consent form   | <input type="text"/> |
| 10 | I agree to take part in the above study   | <input type="text"/> |

-----  
Name of patient (BLOCK CAPITALS)

Date

Signature

-----  
Name of person taking consent

Date

Signature

FOR COMPLETION BY RESEARCHER ONLY

PARTICIPANT ID:

--	--	--	--	--



## **Information about the research**

### **PRACTICED Study**

A randomised trial comparing the effectiveness of cognitive behavior therapy and counselling for depression

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

This information sheet explains the purpose of the study and what will happen if you take part. Please ask us if anything is not clear and talk to others about the study if you wish.

#### **What is the purpose of the study?**

There are different forms of talking treatments for depression. Our research is trying to find out whether there is a difference between two particular approaches in the treatment of depression: Cognitive Behaviour Therapy (CBT) or Counselling for Depression (CfD).

- Counselling for Depression (CfD) aims to address depression by providing the opportunity for clients to talk about underlying feelings. The therapist and client work together to make personal sense of these feelings.
- Cognitive Behaviour Therapy (CBT) looks at how we think about a situation and how this affects the way we act. The therapist and client work together in changing the client's behaviours, or their thinking patterns, or both of these.

The Sheffield IAPT service delivers both these treatments in its routine service. The purpose of this trial will be to see if there are differences between these two treatments and whether some people are more suited to one form of treatment rather than the other. The study will also tell us what it is about the treatments that people like or dislike so that we can improve them for other people.

Both treatments will be for a minimum of 8 sessions and will normally be for up to 16 sessions but can be for up to 20 sessions. Taking part in the study does not affect your right to receive treatment later from the Sheffield IAPT service.

**Why am I being invited to a research assessment?**

You have been invited because you currently have symptoms of depression.

**What is being asked of me at this stage?**

In order to decide whether the study is suited to you, there needs to be an assessment. And in order for one of the researchers to contact you, we need your permission to pass them your contact details as they are not a member of the immediate care team. They do not have access to your medical records.

You can raise any questions you may have about the study with me at your next visit. If you agree to a researcher contacting you, you will be asked to provide details and sign the accompanying *Consent to contact form*. Your response will not affect your current treatment.

A researcher will then send you further information and invite you to an assessment interview. This would be within this area but it may not be at this surgery. The invitation will include a one-day free Sheffield bus pass for you to use so that attending the interview, if it requires a bus ride, will not incur any cost. You will receive this pass whether or not you use it. There is a location in the city centre where assessments can take place if that is convenient.

At the research assessment, you will have the opportunity to ask further questions, before deciding whether to consent to the assessment and inclusion in the study.

You will be free to withdraw from the study at any time, without giving a reason. Leaving the study will not affect the standard of care you receive.

At this stage we do not wish to overload you with information that might turn out not to be relevant. However, if you have any questions, please do ask me at our next meeting.

**Thank you for taking time to read this information sheet**



## Information about the research

### **PRACTICED Study**

A randomised trial comparing the effectiveness of cognitive behavior therapy and counselling for depression

Thank you very much for agreeing to be contacted about the above research study. This information sheet explains the purpose of the study and what will happen if you take part. Please contact us if anything is not clear and talk to others about the study if you wish. You will have a further opportunity to discuss the study with researchers before consenting to full involvement.

#### **What is the purpose of the study?**

Depression is a common problem that affects many people and can sometimes be hard to manage. Experts recommend that people with depression receive a ‘talking treatment’ and/or medication. Your GP may have prescribed some medication for you but this is not always enough on its own. This is where talking therapies can be very helpful.

There are different forms of talking treatments. Our research is trying to find out whether there is a difference between two particular approaches in the treatment of depression: Cognitive Behaviour Therapy (CBT) or Counselling for Depression (CfD).

- Counselling for Depression (CfD) aims to address depression by providing the opportunity for clients to talk about underlying feelings. The therapist and client work together to make personal sense of these feelings.
- Cognitive Behaviour Therapy (CBT) looks at how we think about a situation and how this affects the way we act. The therapist and client work together in changing the client’s behaviours, or their thinking patterns, or both of these.

The Sheffield IAPT service delivers both these treatments in its routine service. The purpose of this trial will be to see if there are differences between these two treatments and whether some people are more suited to one form of treatment rather than the other. The study will also tell us what it is about the treatments that people like or dislike so that we can improve them for other people.

Both treatments will be for a minimum of 8 sessions and will normally be for up to 16 sessions but can be up to 20 sessions. Taking part in the study does not mean that you cannot receive treatment later from the Sheffield service.

**Do I have to take part?**

It is your decision to take part. If you do agree, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. Leaving the study will not affect the standard of care you receive. However, it is always helpful to understand why someone leaves treatment, in order to try and improve services. We will not try to change your decision.

**What will happen to me if I am willing to take part?**

About 3 weeks prior to your therapy starting, a researcher will contact you by your chosen method, to invite you to a one-off assessment interview. This will be based at a location as convenient to you as possible. The invitation to this meeting will include a one-day bus pass in case there is a need to use a bus to attend the meeting. We have done this so that no one is out of pocket for attending this one-off meeting.

At the meeting, you can ask any questions you might have about the study. The researcher will ask you a number of questions that will help to see whether the trial is appropriate. If it is, then you will be informed which treatment you will receive. You stand an equal chance of receiving either treatment. You will then be asked to complete some forms.

You do not have to take part unless you feel completely happy with the study.

**What are the treatments?**

The treatments are Counselling for Depression (CfD) and Cognitive Behaviour Therapy (CBT) and were briefly described earlier.

Both treatments are psychological therapies that have been recommended by NICE (National Institute Clinical Excellence) for the treatment of depression.

**What if I have a very strong preference and don't want to receive one of the treatments?**

People may have a preference for one treatment over the other. This is understandable. However, if you have a very strong preference, such that, you would be unwilling to receive one of the treatments if you were given it, then please talk to the assessor. If after talking with them you feel the same, then the assessor will ensure that you are referred back to the normal service without losing your place on the waiting list.

**How is it decided who gets which treatment?**

Sometimes it is not always clear which is the best way of treating patients. To find out, we need to compare different treatments. We allocate people to one of two treatments then

compare the results to see if one treatment works better for some people while another works better for others.

To try to make sure patients in each treatment are similar to start with, each patient is allocated a treatment by chance. You will have an equal chance of receiving either cognitive behaviour therapy or counselling for depression.

### **What else will be involved if I take part?**

It is standard practice in this service for the sessions to be audiotaped. This is to enable the person you will be seeing to have regular supervision on their work, this is required by the service to ensure we offer the best service.

For the research, a small number of recordings will be listened to by a researcher in order to check the quality of the talking therapy people are receiving. If they do listen to a tape, it will be under strict confidentiality agreements. Some other tapes will also be used as part of the research in order to increase the understanding about how these talking therapies help people who are experiencing depression.

At six months and 12 months after the meeting with the researcher, we will send you a set of questions to see how you are feeling. These will be similar to those forms completed at the start. The actual research study will take 3 years to complete, but you will only be involved for 12 months.

We will ask patients for permission to contact them by their preferred choice (standard mail, email, phone) if they decide to end treatment. This is for us, as researchers, to understand why this has happened. It is not to try to change your decision. However, if you do not wish to take part at that time, then we will respect that decision.

We will also like to conduct some interviews with some people when they complete their treatment. We will not be interviewing everyone but we need your permission to approach you if you are selected. We will only ask about 1 in 10 patients. You do not have to agree to this and saying 'No' will not affect your involvement in the trial or any treatment in the future.

If you are interested in taking part in the separate interview study, we will provide you with more information before you make the decision.

### **What are the possible disadvantages and risks of taking part?**

Both treatments are used in the routine service, so we are not introducing a new treatment. There are no known side effects of either treatment. We are trying to find out a bit more



about what works best for particular people, so we have no reason to believe that any one is being disadvantaged. If you had a strong preference for one treatment, then you will have declared that and the trial would not be appropriate for you.

At any point during the study you can leave without having to give a reason why.

**Will I receive any payment for taking part?**

We will provide a free one-day bus pass to attend the initial assessment (regardless of whether you have to use it or not). We will also enclose a £10 shopping voucher with the questionnaires at 6-months and 12-months. These will be sent to you regardless of whether you complete the forms or not. However, we hope that this will off set the time spent on completing the forms and very much hope you do.

**What happens if new information becomes available during the course of the study?**

Sometimes during a study, new information becomes available about the treatment being studied. If this happens, the research team will tell you and discuss whether you want to continue in the study. If you decide to stop taking part in the study your usual care will continue. If you decide to continue in the study you may be asked to sign an updated consent form. If we think you should withdraw from the study, we will explain the reasons and arrange for your care to continue.

**What happens when the study stops?**

Very occasionally a study is stopped early. If this happens, the reasons will be explained to you and arrangements made for your ongoing care.

**What if there is a problem?**

If you have a concern about any aspect of this study you should ask to speak to the researcher (Lindsey Bishop-Edwards tel: 07710 388985) or the chief investigator, Michael Barkham (tel: 0114 222 0817) who will do their best to answer your questions.

If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact the University Research Practice and Governance Co-ordinator Richard Hudson by email to [r.j.hudson@sheffield.ac.uk](mailto:r.j.hudson@sheffield.ac.uk)

**What will happen to information about me collected during the study?**

All information will be held securely and in strict confidence. Only authorised people working on the study will have access to your information and this is kept securely. Where possible, a unique study ID number will be allocated to replace any identifier and only authorised researchers that need to contact you will have access to your personal contact details.

We will destroy all personal details 5 years after the end of the study.

We keep the health information we collect about you separate from your personal details.

We will use the information we collect to look at how best to help people with depression.

We will keep it 20 years and then destroy it securely.

### **Involvement of your GP**

We will tell your GP that you are taking part in the study. No other results will be given to your GP.

If we are worried that you are having thoughts about harming yourself, we may need to discuss these with your GP. We will, of course, discuss this with you.

### **What will happen to the results of the study?**

When the study is completed, the results will be published in a scientific journal so that health care professionals can see the results. Your identity and personal details will be kept confidential and no named information about you will be published in any reports.

### **Who is organising and funding the study?**

This study is organised by the University of Sheffield. The funder is the British Association of Counselling and Psychotherapy (BACP) Research Foundation.

### **Who has reviewed the study?**

This study has been reviewed by an independent group of people, called the Research Ethics Committee, to protect your safety, rights, well-being and dignity. The study has been given a favourable opinion by NRES Committee Yorkshire & The Humber - South Yorkshire Ethics committee.

### **Who is the study co-ordinator?**

The study co-ordinator can be contacted by telephone on: (07710 388985). Alternatively, you can write to the researcher at:

PRaCTICED

ScHARR

Regent's Court, 30 Regent's Street

Sheffield, S1 4DA

Email: [practiced@sheffield.ac.uk](mailto:practiced@sheffield.ac.uk)

**Thank you for taking time to read this information sheet**